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A 000	INITIAL COMMENTS	A 000		

A full survey was conducted from 08/22/07-08/25/07 to follow up on the outstanding immediate jeopardy (IJ) identified on 08/02/07 and to determine the Hospital's compliance with the Medicare Conditions of Participation.

Based on survey findings, the immediate jeopardy of 08/02/07 was not abated and was determined to be ongoing as evidenced by the following:

Medical record review on 08/23/2007 of Patient #39, a 44 year old female admitted 08/18/07 with a diagnosis of acute psychosis as an involuntary commitment. Upon admission, the patient was assessed by the medical staff and nursing staff with unsteady gait. Medical record review and staff interviews revealed the patient was agitated, refusing to sit still, and continued to walk with an unsteady gait on 08/19/07, requiring the assistance of 2 staff members when ambulating to prevent injury. Staff interviews revealed Patient #39 required the assistance of a staff member on each side while ambulating in the unit hallways. The patient wandered in and out of the designated timeout room several times throughout the day 08/19/07. According to staff interviews, staff failed to provide two man assist while Patient #39, known to present with unsteady gait, wandered into the designated timeout room. Observation of the timeout room revealed a room with concrete walls and an uncarpeted, hard floor. Record reviews and staff interviews revealed the patient "bumped" into the wall in the timeout room on 08/19/07 at 1030 resulting in a laceration at her right eyebrow. The investigation further revealed the patient "bumped" into the wall in the timeout room again at 1230 resulting in bumps and bruises on her left forehead. The patient

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A 000	Continued From page 1 wandered into the timeout room at 1405 at which time Patient #39 fell and hit her head on the floor. The patient was transferred to the Emergency Department of an acute care hospital at 1445 and diagnosed with an open fracture of the skull with intracranial hemorrhage. Patient #39 was subsequently transferred to a tertiary care hospital for neurological intensive care. August 24, 2007, the survey findings resulted in identification of an immediate jeopardy to patients' health and safety beginning on 08/19/07 at 1405. The facility staff failed to provide qualified staff for the monitoring and supervision of an agitated patient with known unsteady gait and failed to ensure the assessment, evaluation and modification of treatment plan for an agitated patient with known unsteady gait to prevent reoccurrence of harm and a fall requiring transfer to an acute care hospital and subsequently tertitiary care hospital for 1 of 1 sampled patients with a known unsteady gait (#39). The findings were discussed with the administrative staff on 08/24/07 at 1630. The administrative staff developed and implemented an action plan to correct the deficiencies on 08/25/07. The IJ was not abated.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by:	A 043		

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A 043	Continued From page 2 Based on review of the hospital's policies, radiology log review, observation, medical record reviews and staff and physician interviews, the hospital's governing body failed to assure systems were in place to ensure assessment, evaluation and modification of treatment plan for an agitated patient with a known unsteady gait to prevent reoccurrence of falls, and subsequent harm, for 1 of 1 sampled patients with a known unsteady gait (#39). The hospital's governing body failed to ensure medical staff accountability and oversight for the quality of care provided by failing to assess, evaluate and modify the treatment plan for a patient with recurrent injuries for 1 of 1 sampled patients with unsteady gait (#39). The governing body failed to oversee coordination of medical staff by failing to ensure physician extenders communicate with supervising physicians and document examination and treatment rendered to ensure safe delivery of care for 1 of 1 sampled patients with unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). The governing body failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days after discharge for 4 of 4 sampled records (#50, 49, 48, 51). The hospital's governing body failed to ensure an organized nursing service as evidenced by failing to ensure registered nursing supervision and evaluation of an agitated patient with known unsteady gait to prevent the occurrence of falls, and subsequently harm, for 1 of 1 sampled patients with a known unsteady gait (#39). The hospital's nursing staff failed meet patient care needs by failing to provide qualified staff to ensure the delivery of safe care for a 44 year-old patient with a known unsteady gait for 1 of 1 sampled patients with unsteady gait (#39).	A 043		

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A 043	Continued From page 3	A 043		

The hospital's nursing staff failed to update the nursing care plan of a 44 year-old patient with known unsteady gait to prevent a fall for 1 of 1 sampled patients with unsteady gait (#39). The hospital's nursing staff failed to assess a change in condition prior to emergency transfer and upon return to the hospital for 1 of 8 sampled patients that were transferred (#4). The governing body failed to ensure medical records systems were in place by failing to ensure completion and authentication of discharge summaries within 30 days for 4 of 4 sampled records (#50, 49, 48 and 51). The governing body failed to ensure systems were in place to ensure minimum radiation exposure to patients by failing to ensure shielding of patients during radiation exposure, and failing to monitor radiation exposure for 3 of 3 sampled staff (#1, 2 and 3).

The findings include:

A) The hospital failed to provide care in a safe setting by failing to assess, evaluate and modify the treatment plan for 1 of 1 sampled patients with repeated injuries related to a known unsteady gait (#39).

~cross refer to 482.13 (c)(2) Patients' Rights Tag A0144

B) The hospital failed to ensure medical staff provided ongoing assessment, monitoring and treatment plan development in the care of a patient to prevent the reoccurrence of falls, and subsequently harm, for 1 of 1 sampled patients with a known unsteady gait (#39).

~cross refer to 482.22 (b) Medical Staff Tag A0347

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A 043	Continued From page 4 C) The hospital's medical staff failed to coordinate medical services by failing to ensure physician extenders communicate with supervising physicians for 1 of 1 sampled patients with unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 D) The hospital's medical staff failed to ensure physician extenders document examination and treatment rendered to ensure safe delivery of care for 1 of 1 sampled patients with a known unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 E) The hospital failed to ensure medical staff assessed a change in condition prior to emergency transfer from the hospital and failed to follow hospital policy to ensure required paperwork for transfer was completed for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 F) The governing body failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days after discharge for 4 of 4 sampled records (#50, 49, 48, 51). ~cross refer to 482.22 (c) Medical Staff Tag A0353	A 043		

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A 043	Continued From page 5 G) The hospital failed to provide adequate qualified staff to assess and supervise the ongoing care needs of Patient #39, an agitated patient with known unsteady gait to ensure the delivery of safe care to prevent the reoccurrent incidents of harm and a fall requiring immediate transfer to an acute care hospital. ~cross refer to 482.23(b) Nursing Services Tag A0392 H) The hospital's nursing staff failed to supervise and evaluate the care of a patient to prevent the reoccurrence of falls, and subsequently harm, for 1 of 1 sampled patients with a known unsteady gait (#39). ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 I) The hospital's nursing staff failed to assess a change in condition prior to emergency transfer and upon return to the hospital for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 J) The hospital's nursing staff failed to update the nursing care plan of a patient to prevent the reoccurrence of falls, and subsequently harm, for 1 of 1 sampled patients with a known unsteady gait (#39). ~cross refer to 482.23 (b)(4) Nursing Services Tag A0396 K) The hospital's medical records department	A 043		

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A 043	Continued From page 6 failed to ensure discharge summaries were authenticated /co-authenticated by the individual(s) responsible for 4 of 4 discharge summaries reviewed, completed by Physician T (patient #50, 49, 48 and 51). ~cross refer to 482.24 (c) (2) (vii) Medical Records Services Tag A0468 L) The hospital failed to ensure minimal radiation exposure to patients by failing to shield patients during radiation exposure. ~cross refer to 482.26 (b) (1) Radiology Services Tag A0536 M) The hospital failed to ensure accurate monitoring of employee radiation exposure for 3 of 3 sampled staff (#1, 2 and 3). ~cross refer to 482.26 (b) (3) Radiology Services Tag A0538	A 043		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on hospital policy review, medical record reviews and staff and physician interviews, the hospital failed to protect the rights of a patient by failing to assess, evaluate and modify the treatment plan for a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39).	A 115		

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A 115	Continued From page 7 The findings include: The hospital failed to provide care in a safe setting by failing to assess, evaluate and modify the treatment plan for a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). ~cross refer to 482.13 (c)(2) Patients' Rights Tag A0144	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, observation and staff and physician interviews the hospital failed to provide care in a safe setting by failing to evaluate and modify the treatment plan for a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). The findings include: Review of current hospital policy #3-11, entitled "Falls, Assessment, Care and Documentation" dated 09/21/05, revealed, "Clinical staff evaluate the factors which place the patient at risk to consider treatment interventions for the prevention of falls. This includes, but is not limited to: ...2. Environmental changes. 3.	A 144		

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A 144	Continued From page 8 Medication reviews. 4. Increased nursing staff supervision ...." Review of current hospital policy #3-19, entitled "Safety Precautions" dated 07/02/07, revealed, "(Name of Hospital) employs precautionary measures to protect patients who are at increased risk for harm, including patients who are suicidal, aggressive and/or vulnerable. Assessing the risk of dangerousness or vulnerability is a continuous interdisciplinary process ....For vulnerable patients, other potentially relevant factors for consideration include: ...Falling ....Consideration is given to interventions that may reduce the patient's risk for harm prior to initiation of and during the implementation of safety precautions, including but not limited to: ...Consultations (e.g., medical, ...) ...Adaptations to environment ...Safety Precaution Level Procedures and Patient Monitoring Requirements: ...Strict: 1. Assigned one-to-one staff keeps the patient under continuous visual observation. 2. Remains within an ordered distance of the patient to decrease the risk of patient injury to self and others ...." Medical record review on 08/23/07 of Patient #39 revealed the patient was a 44 year old female who was admitted on 08/18/07 at 2200 for acute psychosis on an involuntary commitment order. Review of the psychiatric assessment, made by the Psychiatrist A upon admission, revealed the patient had been transferred from an acute care hospital where she was treated for lithium toxicity from 08/05-18/07. Review of the Fall Risk Assessment that was completed on 08/19/07 (untimed) revealed the patient ' s fall risk level was "13 ...at risk for falls	A 144		

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A 144	Continued From page 9 ..." Review of "Safety Precautions Order" written by Psychiatrist B on 08/19/07 at 0108 revealed, "Safety Precaution Level: Strict (Thought processes fragmented, pt [patient] physically very frail, very unsteady gait." Review of RN C's notes dated 08/19/07 at 0150 (at time of admission to the inpatient nursing unit) revealed, "Pt ...also has unsteady gait c (with) fall risk score of 13 ...." Review of nursing documentation dated 08/19/07 at 0230 revealed, "Pt was dizzy c (with) unsteady gait ..." Review of Psychiatrist C's (primary psychiatrist on call) progress note dated 08/19/07 at 1000 revealed, "Called by staff. Pt. grossly psychotic ...She is agitated, walking halls, manic ....She is on 1:1 for vulnerability (one staff member to observe patient at all times)." Review of RN A's (medication nurse) note dated 08/19/07 at 1205 revealed, "Actively hallucinating entire shift to present. Pacing halls, running at times ...(Psychiatrist C) paged and notified of situation at 0915. Orders to give Risperdal 2 mg (milligrams) m-tab (an antipsychotic medication) and Benedryl 50 mg (an antihistamine medication) x 1 (once). Prior to this, @ 0800 med (medication) pass pt. put Seroquel (an antipsychotic medication) in mouth ...and spit it out p (after) leaving med line (place where patients receive medication). Attempting to walk out of locked exit doors. Touching other patients and staff. Redirected to time-out and encouraged to lay down s (without) success. Remains unoriented x 4 (disoriented to person, place, time and situation). (Psychiatrist C) contacted again c	A 144		

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(with) orders to give Ativan 2 mg (given @ 1130); and call back in 1 hour c (with) results. Pt. stumbled into wall r/t (related to) unsteady gait and untied shoe strings and bumped R (right) orbital @ eyebrows. Scant amount of blood noted which was cleaned by writer to reveal a ½ inch laceration. PA (physician's assistant) notified (PA A) who assessed pt c (with) no new orders given. Pupils reactive to light and equal. 0 (no) c/o (complaints of) pain, 0 swelling, bruising. Remains unoriented x 4 (0 change from baseline). Will continue to monitor effectiveness of Ativan."

Medical record review revealed no documentation by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1030.

Review of Psychiatrist D's (psychiatrist 2nd on call) progress note dated 08/19/07 at 1400 revealed, "Pt extremely agitated the whole a.m. and presently ...she is 1:1 but is confused; restless; walking or running away from the staff; fell several times that resulted in bruises; had several meds - not effective/sufficient to protect pt from injury; will start medically related restraints in Geri-chair c (with) the table top and soft restraints on wrists and ankles."

Review of CNA (Certified Nursing Assistant) A's documentation dated 08/19/07 at 1505 revealed, "Pt. 1:1 this shift per volunerbility. Pt. observed within arms length distance @ all times. Pt. would try to go in and out of other peers rooms, trying to touch other patients, attempting to climb walls, each time pt would be redirected by staff. Redirection ineffective. RN notified. PRN (as needed medication) given per (Psychiatrist C) on

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call. Pt would still try to go in other rooms and still attempted to climb walls. After a head hit to the wall, PA notified for injury. Pt. still climbs walls, attempted to run up and down halls. Pt. offered time-out and went in and out of time-out (TO). Pt. would take back out of TO and try to pick up objects out of floor that wasn't there. Pt opened TO door and walked in c (with) 1:1 staff standing in doorway. Stood in front of wall and fell straight back onto floor. RN notified immediately, who notified a PA and other proper precautions ...."

Review of CNA B's documentation dated 08/19/07 (untimed) revealed, "Pt strict for vulnerable for harm, had been exhibiting bizarre behavior this shift, had walked into time-out voluntarily with the door open. Staff stood in front of the doorway observing pt. climbing walls and picking at floor. Pt. had been in and out of time-out, all shift. Staff notified RN, who notified the on-call doctor (Psychiatrist C) of pts. behavior, Dr. wrote order for pt. to have prn (as needed medication), pt. continued climbing walls and bumped head. PA was notified, pt went back on the hall, running up and down hall, staff made many attempts to redirect with no success. Pt. went in time-out room on her on with 1:1 following. Staff heard a thump and notified RN and staff ran in to assist. Where RN and PA took over and assessed pt. Vital signs were taken."

Review of RN A's note dated 08/19/07 at 1500 revealed, "Patient continues to remain actively hallucinating p (after) Ativan 2 mg given @ 1130 per (Psychiatrist C)'s orders. (Required much encouragement to take Ativan). Continues to pace in and out of hall, rooms, day room, timeout room, bathroom. Requiring constant redirection from 1:1 staff. Yelling @ times but speech mainly

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remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2 bruises noted to L forehead c (with) slight swelling @ that time and notified PA. (PA A) assessed pt c (with) 0 new orders. 0 c/o pain. Remains unoriented to person, place, time, situation. (0 change from baseline). Assisted to dining room where pt. refused lunch and drank 20 cc (milliliters) of tea. (Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head and that PA had been contacted c (with) appropriate paper work started. Orders given to give Zyprexa 5 mg (Zydis) (an antipsychotic medication) x 1. Zyprexa Zydis 5 mg given @ 1310. Continued to roam in and out of room, hallway, timeout room, bathroom. Becoming louder c (with) same speech as above present. Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415. Both RNs (writer and [RN B]) into room c (with) 3 CNA staff) ...1:1 staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of Geri-Chair) for safety of patient. Order given @ 1400. Patient laying supine in floor p (after) fall @ 1405 continuing to have flight of ideas, c (with) word salad becoming almost impossible to understand verbally. Words ending in a moan as if in pain. Large amount of swelling noted on physical examination to back of head. Moaning in agony upon touch ..."

Medical record review revealed no documentation

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by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1230.

Observation on 08/22/2007 at 1620 of the timeout room revealed a room with concrete walls and an uncarpeted, hard floor.

Interview with RN A on 08/23/07 at 0900 revealed the nurse came on duty at 0700 on 08/19/07 and was the medication nurse for the day on the unit. Interview revealed the nurse knew Patient #39 was ordered to be on strict observation for vulnerability to harm because the patient's agitated state and unsteady gait placed her at an increased risk for harming herself or being harmed by other patients. Interview revealed the nurse was aware the patient had been identified as a falls risk upon admission. Interview revealed the CNA (CNA A) assigned to the patient was instructed to maintain 1:1 observation and keep the patient within arms reach at all times. Interview revealed that since the physician had not designated the distance of observation on the orders, the nursing staff "always assumes the strictest, which is within arms length at all times". Interview revealed the nurse first observed Patient #39 at approximately 0730, at which time the patient's gait was "more steady" than it was later in the morning. Interview revealed the patient's gait was unsteady when the nurse observed the patient at 1000. Interview revealed "unsteady gait puts a patient at risk for falling". Interview revealed "the 1:1 staff had to hold her (patient's) elbow to support her". Interview revealed the patient was constantly pacing and walking in the hall and tried to enter any open room. Interview revealed the 1:1 staff continually walked with the patient in the hall and had to

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redirect the patient frequently. Interview revealed the patient wandered in and out of the timeout room several times. Interview revealed the timeout room was the same as the seclusion room. Interview revealed the timeout room had unpadded walls and floors that was used as a restrictive intervention to isolate a patient from other patients to ensure the safety of all patients during behavioral outbursts. Interview revealed Patient #39 was not placed in the timeout room as a restrictive intervention, but rather the patient freely wandered in and out of the room. Interview revealed Psychiatrist C was on the unit and saw the patient at approximately 0900. Interview revealed at 0930-1000 the nurse discovered the patient had not swallowed the morning dose of Seroquil (an antipsychotic medication that had been given at 0800). Interview revealed the nurse called Psychiatrist C at approximately 1000 to report the patient's behavior of "pacing the halls, trying to climb the walls, poor articulation, nonstop talking, and word salad" and the fact that the patient had not swallowed her Seroquil. Interview revealed Psychiatrist C ordered Risperdal 2mg and Benedryl 50 mg to be given then, which the nurse gave at 1000. Interview revealed the patient wandered into the timeout room at 1030, at which time she tried to sit on the mattress that was on the floor and bumped her head, resulting in a ½ inch laceration on her right eyebrow. Interview revealed PA A was on the unit making rounds and he "came and looked at the laceration". Interview revealed a Band-Aid was applied to the laceration and no new orders were received. Interview revealed the patient continued to pace and walk the halls accompanied by one, often two, CNAs and the patient was in and out of the timeout room. Interview revealed the patient wouldn't stay in any

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one place for more than a few seconds at the time and continued to have an unsteady gait. Interview revealed the patient's behavior remained unchanged and the nurse notified Psychiatrist C of this fact at 1130, at which time Ativan 2mg was ordered and given to the patient. Interview revealed Psychiatrist C did not come assess the patient. Interview revealed at 1230 the patient again wandered into the timeout room and "bumped her head" on the wall, resulting in 2 bruises to her left forehead. Interview revealed PA A assessed the patient immediately after the second "bump" and no new orders were received. Interview revealed the nurse called Psychiatrist C again at 1310 to report the patient's behavior had not changed, at which time Zyprexa 5mg was ordered and given to the patient. Interview revealed the Zyprexa was given in an effort to "slow her down ...to stop the psychosis". Interview revealed Zyprexa commonly causes drowsiness and "kicks in in about 30-45 minutes, based on what I've seen". Interview revealed, "We were keeping an eye on her." Interview revealed Psychiatrist C did not come assess the patient. Interview revealed Psychiatrist D came up to the unit at approximately 1345. Interview revealed Psychiatrist D ordered medical restraints with a Geri-chair with soft restraints to arms and legs at 1400, after seeing the patient walking in the hall with the assistance of two CNAs. Interview revealed the Geri-chair is not something that is often used on the unit, so the nurse called the house supervisor to locate one. Interview revealed that at1405, before the nurse could get the Geri-chair, the patient "fell in the timeout room". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS.

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A 144	Continued From page 16 CNA A was unavailable for interview. Interview with CNA B on 08/23/07 at 0950 revealed CNA A was the primary CNA assigned to Patient #39 on the morning of 08/19/07 but both CNAs worked with the patient. Interview revealed they "split the 1:1, but most of the day we both worked with her". Interview revealed the CNA knew the patient should be within arms length at all times. Interview revealed the CNA knew the patient had been identified as being at risk for a fall and the staff were to try to help prevent a fall. Interview revealed the patient was "very unsteady when she walked". Interview revealed the patient was constantly in and out of her room and the bathroom and was "still very unsteady". Interview revealed the patient's gait was "real wobbly ...it was like she was overstepping her steps ...she was bumping into the walls ...looked like she was trying to walk up steps". Interview revealed it took both of the CNAs to assist the patient use the bathroom because they had to "hold her up for her to get her clothes down". Interview revealed at one point (unsure of exact time) the patient went in to the timeout room and CNA A was "watching her" at which time CNA A called out, "She walked into the wall." Interview revealed "all of this was reported to the nurses". Interview revealed the two CNAs and PA A took the patient to the treatment room to clean her eye after she bumped her head in the timeout room. Interview revealed the patient would not sit still in the treatment room but they "did manage to get a Band-Aid on her eyebrow". Interview revealed the PA asked the CNA if it had been determined why the patient's speech was so slurred and why she was so unsteady. Interview revealed "this	A 144		

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behavior went on all day long". Interview revealed the patient was "very unsteady walking in the hall" and both CNAs (one on each side of the patient) walked with her continuously when she was in the hall. Interview revealed the patient went into the timeout room (unsure of time) and "we were standing in the doorway looking at her. She (patient) was standing at the window and turned to come toward us. As she was coming she turned and bumped into the wall and got a knot on her forehead". Interview revealed the distance from the window to the doorway is more than arms length (approximately 8 feet). Interview revealed, "I've never been told you have to be in the timeout room with a patient if they are in there voluntarily. My understanding of the strict arms length is if they are not in the timeout room." Interview revealed the CNAs notified the nurse that the patient had bumped her head. Interview revealed the PA came and looked at the bump on the patient's head and said "you can see this will be a bruise and bump". Interview revealed the patient continued to walk and pace in the halls. Interview revealed the CNA did not feel like the patient was safe because "she was still bumping into stuff with two of us watching her ....We reported to (RN A) we have to do something. (RN A) called the psychiatrist". Interview revealed a CNA stayed on each side of the patient while she walked in the hall in an effort to "keep her from bumping into stuff ....I would support her elbow when she would let me". Interview revealed at one point when the CNA tried to redirect the patient from entering another patient's room the patient swung and tried to hit the CNA. Interview revealed when the patient swung at the staff member she was unsteady so they "held her so she wouldn't fall". Interview revealed the patient again went into the timeout room and CNA

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A "stood in the door watching her". Interview revealed, "I was taking the trash past the timeout room door and I heard 'Boom'. I looked and she (patient) was on the floor". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS.

Interview with PA A on 08/23/07 at 1100 revealed the PA was on the unit on the morning of 08/19/07 because he had to do admission physical assessments on several newly admitted patients, including Patient #39. Interview revealed the PA observed the patient in the hall "with two CNAs with her at all times". Interview revealed the patient's gait was "a little unsteady with a jumpy kind of walk". Interview revealed the patient would "miss a step now and then and would have to regain her balance". Interview revealed the PA was reviewing patient charts (unsure of time) when "the nurse told me she (patient) hit her head on the wall and had cut her left eyebrow ....I looked at it and put a Band-Aid on it." Interview revealed the nursing staff told the PA the patient had an unsteady walk and bumped her head into the wall. Interview revealed the PA did not adjust the treatment plan at that time or notify his supervising physician of the patient's condition. Interview revealed about 1-1 ½ hours later "the nurse told me she bumped her head again and I went to the timeout room and looked at her head". Interview revealed the patient's forehead was "maybe a little reddened" from the bump. Interview revealed the PA did not adjust the treatment plan at that time or notify his supervising physician or the psychiatrist of the patient's condition. Interview revealed the PA then left the unit for a while until the nurse called

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him back (unsure of time) and said "come right away". Interview revealed the nurse report the patient had fallen backwards and hit her head on the floor in the timeout room. Interview revealed the PA and Psychiatrist C arrived to the timeout room at the same time. Interview revealed they attended to the patient until EMS arrived and transported the patient to an acute care hospital's emergency department. Interview revealed only a psychiatrist can order "restrictive measures". Interview revealed the PA had not requested the nursing staff to call the psychiatrist after either of the head bumps.

Telephone interview with Psychiatrist C on 08/23/07 at 1115 revealed the psychiatrist had been on staff at the hospital for one week. Interview revealed the psychiatrist was the primary on call psychiatrist for the hospital on 08/19/07. Interview revealed the nurse had notified the psychiatrist in the morning (unsure of time) that Patient #39 had not swallowed her morning dose of Seroquil and the patient was very agitated and was exhibiting psychotic behavior. Interview revealed the psychiatrist ordered Risperdal M-tab to be given at that time. Interview revealed the nurse called again an hour to hour and a half later and said the patient was still very agitated and wouldn't stop walking. Interview revealed the psychiatrist then ordered Benedryl to be given. Interview revealed that sometimes Risperdal and Benedryl are ordered to be given at the same time for acute psychosis, but the psychiatrist did not order it that way in this case because the patient was very small and thin. Interview revealed the nurse called the psychiatrist again about one hour later and said the patient was still very agitated and was crawling on the floor. Interview revealed the

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nurse then said the patient had laid on the mattress in the timeout room and bumped her head on the wall. Interview revealed the "nurse said something like she had stumbled and hit her head." Interview revealed the information related to the incident was "presented more like she tripped and bumped her head". Interview revealed the nurse did not report that the patient had an unsteady gait. Interview revealed the psychiatrist was aware the PA had seen the patient after the bump and if he had concerns he should have called his supervising physician, who is an internist. Interview revealed at that time the psychiatrist ordered for the patient to receive Ativan. Interview revealed the nurse called again about 1 ½ hours later and said the patient was restless and walking around agitated with the 1:1 CNA having to walk up and down the hall with her. Interview revealed "agitated was the word they kept using". Interview revealed, "I called (Psychiatrist D - 2nd on call that day) to discuss what else we could give her (patient)". Interview revealed the psychiatrist then ordered for the patient to be given Zyprexa. Interview revealed the psychiatrist knew that Psychiatrist D was going to be making rounds on the unit soon after their conversation. Interview revealed the Psychiatrist C was on another unit when she "heard them say they want a PA right now on the women's ward". Interview revealed the psychiatrist went to the women's ward at that time and the patient was laying on the floor in the treatment room. Interview revealed " we assessed her and sent her to the hospital".

Telephone interview with Psychiatrist D on 08/25/07 at 0915 revealed she was the 2nd on call psychiatrist on 08/19/07 and was therefore making rounds on the units. Interview revealed

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Psychiatrist C had called her at some point that morning (unsure of time) and discussed Patient #39 with her. Interview revealed they discussed the level of the patient's agitation and possible medication plans for treatment. Interview revealed she told her the patient was on 1:1 monitoring for vulnerability and had "already fallen" but didn't say why. Interview revealed that Psychiatrist C did not ask her to go see the patient, but rather that she knew Psychiatrist D would be making rounds on the unit soon anyway. Interview revealed nursing staff had not notified her of the patient's condition at any point, because they were communicating with Psychiatrist C. Interview revealed Psychiatrist D went to the unit at approximately 1345 for rounds. Interview revealed, "I saw the patient walking in the hall with 2 staff members." Interview revealed the patient had an unsteady gait. Interview revealed, "When I saw what was going on I said the only way to prevent her from falling was to put her in the Geri-chair." Interview revealed she felt the Geri-chair with soft restraints was necessary to protect the patient. Interview revealed after the psychiatrist saw the patient, she thought "it was an accident waiting to happen ....they (the staff) knew it ...they were aware of it". Interview revealed the patient fell before the nursing staff could execute the order for medical restraints. Interview revealed that medical restraints are unusual on a psychiatric unit, but they can be used there and are sometimes necessary. Interview revealed an unsteady gait is uncommon for a patient with acute psychosis. Interview revealed these patients' movements are often very coordinated "unless they have too much medication or something". Interview revealed a PA with concerns about a patient could contact his supervising physician (an internist) or the

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psychiatrist for guidance.

Interview with administrative nursing staff on 08/24/07 at 1530 revealed the nursing staff present at the time of the fall had notified the administrator at home. Interview revealed a Serious Incident Notification had been done by the house supervisor, which prompted an internal investigation into the incident. Interview revealed the investigation included a review of the medical record and related incident report, as well as staff interviews. Interview revealed no Root Cause Analysis had been initiated. Interview revealed the administrator of the division and the nurse manager (both present at interview) both felt the care and monitoring provided for the patient on 08/19/07 had been appropriate. Interview revealed after reviewing the information obtained during the internal investigation, including the medical record, the administrator and nurse manager's main concern was that the nurse had called 911 directly, rather than following the hospital's procedure of calling the in house operator. Interview revealed the nurse manager thought that the patient's treatment plan was appropriately adjusted because the nursing staff maintained 1:1 monitoring and called the physician for medication adjustments throughout the shift on which the fall occurred.

Consequently, nursing services, medical and psychiatric physicians failed to coordinate the physical and behavioral care needs of Patient #39, 44 year old patient with a diagnosis of psychosis and known unsteady gait. Facility staff failed to adequately supervise the wandering of Patient #39. As a result, Patient #39 sustained 3 injuries on 08/19/07, at 1030, 1230 and 1405, subsequently requiring transfer to an acute care

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A 144	Continued From page 23 hospital for emergency treatment.	A 144		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on review of the hospital's policies, medical record reviews and staff and physician interviews, the hospital's medical staff failed to provide accountability and oversight for the quality of care provided by failing to assess, evaluate and modify the treatment plan for a patient with recurrent injuries for 1 of 1 sampled patients with a known unsteady gait (#39). The medical staff failed to coordinate care by failing to ensure physician extenders communicate with supervising physicians and document examination and treatment rendered to ensure safe delivery of care for 1 of 1 sampled patients with known unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). The hospital's medical staff failed to assess a change in condition prior to emergency transfer and upon return to the hospital for 1 of 8 sampled patients that were transferred (#4). The medical staff failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days after discharge for 4 of 4 sampled records (#50, 49, 48, 51). The findings include:	A 338		

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A 338	Continued From page 24 A) The hospital's medical staff failed to provide oversight in the care of a patient to prevent repeated injuries related to a known unsteady gait for 1 of 1 patients with an unsteady gait reviewed (#39). ~cross refer to 482.22 (b) Medical Staff Tag A0347 B) The hospital's medical staff failed to coordinate medical services by failing to ensure physician extenders communicate with supervising physicians for 1 of 1 sampled patients with a known unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 C) The hospital's medical staff failed to ensure physician extenders document examination and treatment rendered to ensure safe delivery of care for 1 of 1 sampled patients with a known unsteady gait (#39) and 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 D) The hospital's medical staff failed to assess a change in condition prior to emergency transfer and upon return to the hospital for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 E) The medical staff failed to follow hospital policy to ensure required paperwork for transfer was	A 338		

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A 338	Continued From page 25 completed for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.22 (b) Medical Staff Tag A0347 F) The medical staff failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days after discharge for 4 of 4 sampled records (#50, 49, 48, 51). ~cross refer to 482.22 (c) Medical Staff Tag A0353	A 338		
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner approved by the governing body. If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine.	A 347		

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This STANDARD is not met as evidenced by:
Based on medical record reviews, staff and physician interviews, and review of facility policies and procedures, the hospital's medical staff failed to:

A) The hospital's medical staff failed to provide oversight of physician extenders and oversight in the care of a patient to prevent repeated injuries related to a known unsteady gait for 1 of 1 patients with an unsteady gait reviewed (#39), and

B) assess a change in condition prior to emergency transfer and upon return to the hospital, and failed to follow hospital policy to ensure required paperwork for transfer was completed for 1 of 8 sampled patients that were transferred (#4).

The findings include:

A) Medical record review on 08/23/07 of Patient #39 revealed the patient was a 44 year old female who was admitted on 08/18/07 at 2200 for acute psychosis on an involuntary commitment order. Review of the psychiatric assessment, made by the Psychiatrist A upon admission, revealed the patient had been transferred from an acute care hospital where she was treated for lithium toxicity from 08/05-18/07.

Review of "Safety Precautions Order" written by Psychiatrist B on 08/19/07 at 0108 revealed, "Safety Precaution Level: Strict (Thought

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processes fragmented, pt [patient] physically very frail, very unsteady gait."

Review of a physician's telephone order dated 08/19/07 at 0935 (and signed by Psychiatrist C on 08/19/07) revealed, "Give Risperdal m-tab 2 mg (milligram) po (by mouth) x 1 now and Benedryl 50 mg po x 1 now - psychosis". Review of the medication administration record (MAR) revealed Risperdal m-tab 2mg and Benedryl 50 mg were both given by mouth at 1000.

Review of Psychiatrist C's (primary psychiatrist on call) progress note dated 08/19/07 at 1000 revealed, "Called by staff. Pt. grossly psychotic...She is agitated, walking halls, manic....She is on 1:1 for vulnerability (one staff member to observe patient at all times)."

Review of a physician's telephone order (given by Psychiatrist C) dated 08/19/07 at 1125 revealed, "Give Ativan 2 mg po x 1 now. Call Dr. back in 1 hr (hour) c (with) results of PRN (as needed medication)." Review of the MAR revealed Ativan 2 mg was given by mouth at 1130.

Review of a physician's telephone order (given by Psychiatrist C) dated 08/19/07 at 1300 revealed, "Give Zyprexa Zydis 5 mg PO x 1 now - psychosis." Review of the MAR revealed Zyprexa Zydis 5 mg was given by mouth at 1310.

Review of Psychiatrist D's (psychiatrist 2nd on call) progress note dated 08/19/07 at 1400 revealed, "Pt extremely agitated the whole a.m. and presently...she is 1:1 but is confused; restless; walking or running away from the staff; fell several times that resulted in bruises; had several meds - not effective/sufficient to protect pt

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from injury; will start medically related restraints in Geri-chair c (with) the table top and soft restraints on wrists and ankles."

Review of RN A's (medication nurse) note dated 08/19/07 at 1205 revealed, "Actively hallucinating entire shift to present. Pacing halls, running at times...(Psychiatrist C) paged and notified of situation at 0915. Orders to give Risperdal 2 mg (milligrams) m-tab (an antipsychotic medication) and Benedryl 50 mg (an antihistamine medication) x 1 (once). Prior to this, @ 0800 med (medication) pass pt. put Seroquel (an antipsychotic medication) in mouth...and spit it out p (after) leaving med line (place where patients receive medication). Attempting to walk out of locked exit doors. Touching other patients and staff. Redirected to time-out and encouraged to lay down s (without) success. Remains unoriented x 4 (disoriented to person, place, time and situation). (Psychiatrist C) contacted again c (with) orders to give Ativan 2 mg (given @ 1130); and call back in 1 hour c (with) results. Pt. stumbled into wall r/t (related to) unsteady gait and untied shoe strings and bumped R (right) orbital @ eyebrows. Scant amount of blood noted which was cleaned by writer to reveal a ½ inch laceration. PA (physician's assistant) notified (PA A) who assessed pt c (with) no new orders given. Pupils reactive to light and equal. 0 (no) c/o (complaints of) pain, 0 swelling, bruising. Remains unoriented x 4 (0 change from baseline). Will continue to monitor effectiveness of Ativan."

Medical record review revealed no documentation by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1030.

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Review of RN A's (the medication nurse) note dated 08/19/07 at 1500 revealed, "Patient continues to remain actively hallucinating p (after) Ativan 2 mg given @ 1130 per (Psychiatrist C)'s orders. (Required much encouragement to take Ativan). Continues to pace in and out of hall, rooms, day room, timeout room, bathroom. Requiring constant redirection from 1:1 staff. Yelling @ times but speech mainly remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2 bruises noted to L forehead c (with) slight swelling @ that time and notified PA. (PA A) assessed pt c (with) 0 new orders. 0 c/o pain. Remains unoriented to person, place, time, situation. (0 change from baseline). Assisted to dining room where pt. refused lunch and drank 20 cc (milliliters) of tea. (Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head and that PA had been contacted c (with) appropriate paper work started. Orders given to give Zyprexa 5 mg (Zydis) (an antipsychotic medication) x 1. Zyprexa Zydis 5 mg given @ 1310. Continued to roam in and out of room, hallway, timeout room, bathroom. Becoming louder c (with) same speech as above present. Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415. Both RNs (writer and [RN B]) into room c (with) 3 CNA staff)...1:1 staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of

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Geri-Chair) for safety of patient. Order given @ 1400. Patient laying supine in floor p (after) fall @ 1405 continuing to have flight of ideas, c (with) word salad becoming almost impossible to understand verbally. Words ending in a moan as if in pain. Large amount of swelling noted on physical examination to back of head. Moaning in agony upon touch ..."

Medical record review revealed no documentation by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1230.

Interview with RN A on 08/23/07 at 0900 revealed the nurse came on duty at 0700 on 08/19/07 and was the medication nurse for the day on the unit. Interview revealed the nurse knew Patient #39 was ordered to be on strict observation for vulnerability to harm. Interview revealed the nurse was aware the patient had been identified as a falls risk upon admission. Interview revealed the CNA assigned to the patient was instructed to maintain 1:1 observation and keep the patient within arms reach at all times. Interview revealed that since the physician had not designated the distance of observation on the orders, the nursing staff "always assumes the strictest, which is within arms length at all times". Interview revealed the nurse first observed Patient #39 at approximately 0730, at which time the patient's gait was "more steady" than it was later in the morning. Interview revealed the patient's gait was unsteady when the nurse observed the patient at 1000. Interview revealed "unsteady gait puts a patient at risk for falling" . Interview revealed "the 1:1 staff had to hold her (patient's) elbow to support her". Interview revealed the patient was constantly pacing and walking in the hall and tried

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to enter any open room. Interview revealed the 1:1 staff continually walked with the patient in the hall and had to redirect the patient frequently. Interview revealed the patient wandered in and out of the time-out room several times. Interview revealed the timeout room was the same as the seclusion room. Interview revealed the timeout room had unpadded walls and floors that was used as a restrictive intervention to isolate a patient from other patients to ensure the safety of all patients during behavioral outbursts. Interview revealed Patient #39 was not placed in the timeout room as a restrictive intervention, but rather the patient freely wandered in and out of the room. Interview revealed Psychiatrist C was on the unit and saw the patient at approximately 0900. Interview revealed at 0930-1000 the nurse discovered the patient had not swallowed the morning dose of Seroquil (an antipsychotic medication that had been given at 0800). Interview revealed the nurse called Psychiatrist C at approximately 1000 to report the patient's behavior of "pacing the halls, trying to climb the walls, poor articulation, nonstop talking, and word salad" and the fact that the patient had not swallowed her Seroquil. Interview revealed Psychiatrist C ordered Risperdal 2mg and Benedryl 50 mg to be given then, which the nurse gave at 1000. Interview revealed the patient wandered into the timeout room at 1030, at which time she tried to sit on the mattress that was on the floor and bumped her head, resulting in a ½ inch laceration on her right eyebrow. Interview revealed PA A was on the unit making rounds and he "came and looked at the laceration" . Interview revealed a Band-Aid was applied to the laceration and no new orders were received. Interview revealed the patient continued to pace and walk the halls accompanied by one, often

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two, CNAs and the patient was in and out of the timeout room. Interview revealed the patient wouldn't stay in any one place for more than a few seconds at the time and continued to have an unsteady gait. Interview revealed the patient's behavior remained unchanged and the nurse notified Psychiatrist C of this fact at 1130, at which time Ativan 2mg was ordered and given to the patient. Interview revealed Psychiatrist C did not come assess the patient. Interview revealed at 1230 the patient again wandered into the timeout room and "bumped her head" on the wall, resulting in 2 bruises to her left forehead. Interview revealed PA A assessed the patient immediately after the second "bump" and no new orders were received. Interview revealed the nurse called Psychiatrist C again at 1310 to report the patient's behavior had not changed, at which time Zyprexa 5mg was ordered and given to the patient. Interview revealed the Zyprexa was given in an effort to "slow her down...to stop the psychosis" . Interview revealed Zyprexa commonly causes drowsiness and "kicks in in about 30-45 minutes, based on what I've seen" . Interview revealed, "We were keeping an eye on her." Interview revealed Psychiatrist C did not come assess the patient. Interview revealed Psychiatrist D came up to the unit at approximately 1345. Interview revealed Psychiatrist D ordered medical restraints with a Geri-chair with soft restraints to arms and legs at 1400, after seeing the patient walking in the hall with the assistance of two CNAs. Interview revealed the Geri-chair is not something that is often used on the unit, so the nurse called the house supervisor to locate one. Interview revealed that at1405, before the nurse could get the Geri-chair, the patient "fell in the timeout room". Interview revealed the nurse, PA and

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Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS.

Interview with PA A on 08/23/07 at 1100 revealed the PA was on the unit on the morning of 08/19/07 because he had to do admission physical assessments on several newly admitted patients, including Patient #39. Interview revealed the PA observed the patient in the hall "with two CNAs with her at all times". Interview revealed the patient's gait was "a little unsteady with a jumpy kind of walk". Interview revealed the patient would "miss a step now and then and would have to regain her balance". Interview revealed the PA was reviewing patient charts (unsure of time) when "the nurse told me she (patient) hit her head on the wall and had cut her left eyebrow...I looked at it and put a Band-Aid on it." Interview revealed the nursing staff told the PA the patient had an unsteady walk and bumped her head into the wall. Interview revealed the PA did not adjust the treatment plan at that time or notify his supervising physician of the patient ' s condition. Interview revealed about 1-1 ½ hours later "the nurse told me she bumped her head again and I went to the timeout room and looked at her head". Interview revealed the patient ' s forehead was "maybe a little reddened" from the bump. Interview revealed the PA did not adjust the treatment plan at that time or notify his supervising physician of the patient's condition. Interview revealed the PA then left the unit for a while until the nurse called him back (unsure of time) and said "come right away". Interview revealed the nurse report the patient had fallen backwards and hit her head on the floor in the timeout room. Interview revealed the PA and Psychiatrist C arrived to the timeout room at the

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same time. Interview revealed they attended to the patient until EMS arrived and transported the patient to an acute care hospital's emergency department. Interview revealed only a psychiatrist can order "restrictive measures". Interview revealed the PA had not requested the nursing staff to call the psychiatrist after either of the head bumps.

Telephone interview with Psychiatrist C on 08/23/07 at 1115 revealed the psychiatrist had been on staff at the hospital for one week. Interview revealed the psychiatrist was the primary on call psychiatrist for the hospital on 08/19/07. Interview revealed the nurse had notified the psychiatrist in the morning (unsure of time) that Patient #39 had not swallowed her morning dose of Seroquil and the patient was very agitated and was exhibiting psychotic behavior. Interview revealed the psychiatrist ordered Risperdal M-tab to be given at that time. Interview revealed the nurse called again an hour to hour and a half later and said the patient was still very agitated and wouldn't stop walking. Interview revealed the psychiatrist then ordered Benedryl to be given. Interview revealed that sometimes Risperdal and Benedryl are ordered to be given at the same time for acute psychosis, but the psychiatrist did not order it that way in this case because the patient was very small and thin. Interview revealed the nurse called the psychiatrist again about one hour later and said the patient was still very agitated and was crawling on the floor. Interview revealed the nurse then said the patient had laid on the mattress in the timeout room and bumped her head on the wall. Interview revealed the "nurse said something like she had stumbled and hit her head." Interview revealed the information related

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to the incident was "presented more like she tripped and bumped her head". Interview revealed the nurse did not report that the patient had an unsteady gait. Interview revealed the psychiatrist was aware the PA had seen the patient after the bump and if he had concerns he should have called his supervising physician, who is an internist. Interview revealed at that time the psychiatrist ordered for the patient to receive Ativan. Interview revealed the nurse called again about 1 ½ hours later and said the patient was restless and walking around agitated with the 1:1 CNA having to walk up and down the hall with her. Interview revealed "agitated was the word they kept using". Interview revealed, "I called (Psychiatrist D - 2nd on call that day) to discuss what else we could give her (patient)". Interview revealed the psychiatrist then ordered for the patient to be given Zyprexa. Interview revealed the psychiatrist knew that Psychiatrist D was going to be making rounds on the unit soon after their conversation. Interview revealed the Psychiatrist C was on another unit when she "heard them say they want a PA right now on the women's ward". Interview revealed the psychiatrist went to the women's ward at that time and the patient was laying on the floor in the treatment room. Interview revealed "we assessed her and sent her to the hospital".

Telephone interview with Psychiatrist D on 08/25/07 at 0915 revealed she was the 2nd on call psychiatrist on 08/19/07 and was therefore making rounds on the units. Interview revealed Psychiatrist C had called her at some point that morning (unsure of time) and discussed Patient #39 with her. Interview revealed they discussed the level of the patient's agitation and possible medication plans for treatment. Interview

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revealed she told her the patient was on 1:1 monitoring for vulnerability and had "already fallen" but didn't say why. Interview revealed that Psychiatrist C did not ask her to go see the patient, but rather that she knew Psychiatrist D would be making rounds on the unit soon anyway. Interview revealed nursing staff had not notified her of the patient's condition at any point, because they were communicating with Psychiatrist C. Interview revealed Psychiatrist D went to the unit at approximately 1345 for rounds. Interview revealed, "I saw the patient walking in the hall with 2 staff members." Interview revealed the patient had an unsteady gait. Interview revealed, "When I saw what was going on I said the only way to prevent her from falling was to put her in the Geri-chair." Interview revealed she felt the Geri-chair with soft restraints was necessary to protect the patient. Interview revealed after the psychiatrist saw the patient, she thought "it was an accident waiting to happen....they (the staff) knew it...they were aware of it". Interview revealed the patient fell before the nursing staff could execute the order for medical restraints. Interview revealed that medical restraints are unusual on a psychiatric unit, but they can be used there and are sometimes necessary. Interview revealed an unsteady gait is uncommon for a patient with acute psychosis. Interview revealed these patients' movements are often very coordinated "unless they have too much medication or something". Interview revealed a PA with concerns about a patient could contact his supervising physician (an internist) or the psychiatrist for guidance.

Consequently, nursing services, medical and psychiatric physicians failed to coordinate the physical and behavioral care needs of Patient

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A 347	Continued From page 37 #39, 44 year old patient with a diagnosis of psychosis and known unsteady gait. Facility staff failed to adequately supervise the wandering of Patient #39. As a result, Patient #39 sustained 3 injuries on 08/19/07, at 1030, 1230 and 1405, subsequently requiring transfer to an acute care hospital for emergency treatment. B) Review of the hospital's "Medical Transfer to Other Hospitals, Referral" policy effective September 20, 2006 reveals "II. B. 1. Every attempt is made by the attending physician/designee to contact the receiving facility about the transfer. If there are difficulties or delays in contacting the receiving facility, this is documented in the medical record. If it is an emergency, call 911 to transport by EMS (emergency transport), and inform the receiving hospital of the transfer. 2. The attending physician should attempt to contact the receiving physician by telephone to ensure that hand-off communication has been provided. Documentation of such contact and an overview of the discussion should be charted in the progress section of the chart. Note: If unable to contact the receiving physician, document such efforts. III. A. Physician writes transfer order on physician's order form. E. Complete the Off Campus Transfer Summary/Consult Referral (Send one copy to the receiving facility ...and file the original in the miscellaneous section of the chart." Closed record review on 08/23/2007 of Patient #4 revealed a 41 year-old female that was admitted 07/26/2007 with major depression and discharged 07/30/2007. Record review revealed the patient was transferred from an acute hospital (Hospital C) emergency department (ED) due to a suicide	A 347		

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attempt. Review of records from Hospital C's ED revealed a pregnancy test dated 07/25/2007 was negative. Review of the physician's history and physical exam dictated 07/28/2007 revealed the patient's "LMP (last menstrual period): patient has her menses and her periods are irregular." Nursing progress notes dated 07/29/2007 at 1225 documented "Patient was in restroom this AM and came out requesting help. Patient had bright red blood running down both inner thighs. Patient stated 'I think I had a miscarriage.' Patient reports a history of miscarriages. Patient evaluated by PA (Physician's Assistant). PA called EMS (emergency transport). EMS transported to (acute Hospital B)." Review of the record revealed no assessment of the vital signs documented when the patient reported the bleeding and no documented assessment of the amount of blood loss, duration of bleeding, assessment of last menstrual period or level of consciousness. Further review of the record revealed no physician's order to transfer the patient and no documentation of an examination by the PA. The review revealed no documentation of what time the patient was transferred or returned to the hospital, and no documentation of the patient ' s condition upon return from the acute care hospital's emergency department.

Review of the transferring hospital's (Hospital B) emergency department record revealed Patient #4 arrived via EMS on 07/29/2007 at 1107 with a chief complaint of "spotting times four days, increased vaginal bleeding today, negative pregnancy test on 07/25/2007." The record revealed the patient was accompanied by a CNA (certified nursing assistant). Record review revealed orthostatic blood pressures, lab studies

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A 347	Continued From page 39 and a pelvic exam were completed in the emergency department. Review of the ED physician's documentation revealed a diagnosis of "dysmennorrhea" and the patient was discharged. Further review of the record failed to reveal a time of discharge. Interview on 08/24/2007 at 0830 with the PA that was working on 07/29/2007 when the patient was transferred (PA B) revealed he was asked to come check the patient. He stated "She was in the bathroom stall. Blood was flowing out of her ...not pooling ...sanitary pad was soaked. She said it had just started and was not normal for her. She was afraid. She said she thought she was having a miscarriage. I did not do a vaginal exam at that time. I felt she needed to go out urgently. There was a physician on call. I did not feel she needed to be delayed. She needed to be in an emergency room ....needed immediate referral to specialty services. I asked telecom to call EMS ....I don ' t remember if I completed the transfer paperwork. It can ' t be found ..... I did not write an order to transfer the patient .... I did not call the ED physician. I did call the ED nurse. I did not document that I called the ED nurse...For the past year, we don't have a good relationship with (Hospital B's ED). The physicians won't talk with us. They are worried that we won't take the patients back. It is a waste of time trying to call them."	A 347		
A 353	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. This STANDARD is not met as evidenced by:	A 353		

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Based on policy and procedure review, medical records department reports review, staff interview, and physician interview, the hospital failed to enforce Medical Staff Bylaws/hospital policies, by failing to ensure physician completion of medical records within 30 days of discharge for 4 of 4 sampled discharge summaries completed by Physician T (patient #50, 49, 48 and 51).

The findings include:

Review of the hospital's "Record Entries, Quantitative" policy dated 05/25/2007, revealed "Discharge Summary No later than 15 Days (Dictated) No later than 30 Days (Complete)".

Review of "Medical Records Delinquency Rate for Chart Completion" report dated June 2006 - June 2007 revealed the "Target" Delinquency Rate of 25%. Review of the report revealed delinquent record rates ranging from 40% to 69%. Review of the report revealed the two leading causes of delinquent records are, Discharge Summary not dictated (16.9% to 53.8%), and Discharge Summary dictated late (4.9% to 30.6%).

Interview on 08/24/2007 at 1340 with the Health Information Management Manager revealed the hospital has had an increase in delinquent records since December 2006. The interview revealed the system in place at this time is for dictation to be completed via telephone, which has limits due to ability to call into the system and phone availability. The interview revealed the hospital is going to be transitioning to Digital Dictation when the equipment is available. The interview revealed medical records staff monitor delinquency rates and twice weekly send non compliant providers notification of delinquent

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records needing dictation. The interview revealed the Clinical Director is also notified of provider delinquent record status. The interview revealed the Medical Records Manager does not have means to enforce the requirement to complete the records timely. The interview revealed the Clinical Director is responsible to enforce the requirements with providers. The interview revealed in July 2007 the hospital started to use the services of a Locum Tenens Physician to assist in "catching up" on delinquent records by having the physician complete delinquent discharge summaries.

Interview on 08/25/2007 at 1435 with the Clinical Director revealed the Director is aware of the Medical Records delinquency rates. The interview revealed the hospital had some physicians leave and currently has 6 vacant positions, 3 of which are newly created positions. The interview revealed the remaining providers are covering the responsibilities included in the open positions. The interview revealed Department Clinical Directors are responsible for providers in their departments and if a provider leaves then the Director is responsible for completion of any delinquent records of that provider. The interview revealed the Director has authorized overtime for providers in order to complete delinquent records, stating "getting caught up can be a problem within regular hours." The interview revealed individual providers may be removed from clinical areas for a day, in order to catch up when they reach a delinquent record rate of 50%. The interview revealed "I am swamped and needed help" catching up on delinquent records. The interview revealed the hospital has brought in a Locum Tenens Physician to assist with completion of delinquent

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records. The interview revealed the Clinical Directors office is responsible for directing Physician T's dictation of delinquent discharge summaries. The interview revealed Physician T is not involved in the patient care, and completes the discharge summary as a service to the hospital. The interview revealed there is no requirement for providers to co-authenticate the discharge summaries completed by Physician T, for accuracy and completeness.

1. Record review on 08/25/2007 revealed patient #50 discharged from the hospital on 02/09/2007 (4 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/16/2007 (5 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T.

2. Record review on 08/25/2007 revealed patient #49 discharged from the hospital on 05/11/2007 (1 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 08/13/2007 (3 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T.

3. Record review on 08/25/2007 revealed patient #48 discharged from the hospital on 02/09/2007 (4 months prior to Physician T ' s appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/06/2007 (5 months after the patients discharge). Review of the discharge summary failed to reveal co-authentication of the discharge summary by the physician responsible for the patient's treatment during the hospitalization.

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A 353	Continued From page 43 4. Record review on 08/25/2007 revealed patient #51 discharged from the hospital on 01/23/2007 (4.5 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/02/2007 (6 months after the patients discharge). Review of the discharge summary failed to reveal co authentication of the discharge summary by the physician responsible for the patient's treatment during the hospitalization.	A 353		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on review of the hospital's policies, medical record reviews, observation and staff and physician interviews, the hospital failed to have an organized nursing service. The registered nurse failed to provide supervision by failing to assess, evaluate and adjust the treatment plan and assure trained staff were assigned to provide care for a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). The findings include: A) The hospital failed to provide adequate	A 385		

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A 385	Continued From page 44 qualified staff to assess and supervise the ongoing care needs of 1 of 1 sampled patients with an unsteady gait (#39), an agitated patient with known unsteady gait to ensure the delivery of safe care to prevent the reoccurrent incidents of harm and a fall requiring immediate transfer to an acute care hospital. ~cross refer to 482.23(b) Nursing Services Tag A0392 B) The hospital's nursing staff failed to supervise and evaluate the care of a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 C) The hospital's nursing staff failed to assess a change in condition prior to emergency transfer and upon return to the hospital for 1 of 8 sampled patients that were transferred (#4). ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 D) The hospital's nursing staff failed to update the nursing care plan of a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). ~cross refer to 482.23 (b)(4) Nursing Services Tag A0396 E) The hospital's nursing staff failed to follow the physician's order for a medical alert to obtain the patient's blood pressure prior to 45 of 91 administrations of a hypotensive medication for 1	A 385		

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A 385	Continued From page 45 of 21 sampled open records (#45). ~cross refer to 482.23 (c) Nursing Services Tag A0404	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, observation and physician and staff interviews, the hospital failed to provide adequate qualified staff to assess and supervise the ongoing care needs of an agitated patient with known unsteady gait for 1 of 1 sampled patients with unsteady gait (#39) to ensure the delivery of safe care to prevent the reoccurrent incidents of harm and a fall requiring immediate transfer to an acute care hospital. The findings include: Review of current hospital policy #3-11, entitled "Falls, Assessment, Care and Documentation"	A 392		

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dated 09/21/05, revealed, "Clinical staff evaluate the factors which place the patient at risk to consider treatment interventions for the prevention of falls. This includes, but is not limited to: ...3. Medication reviews. 4. Increased nursing staff supervision ...."

Review of current hospital policy #3-19, entitled "Safety Precautions" dated 07/02/07, revealed, "(Name of Hospital) employs precautionary measures to protect patients who are at increased risk for harm, including patients who are suicidal, aggressive and/or vulnerable. Assessing the risk of dangerousness or vulnerability is a continuous interdisciplinary process ....For vulnerable patients, other potentially relevant factors for consideration include: ...Falling ....Consideration is given to interventions that may reduce the patient's risk for harm prior to initiation of and during the implementation of safety precautions, including but not limited to: ...Consultations (e.g., medical, ...) ...Adaptations to environment ...Safety Precaution Level Procedures and Patient Monitoring Requirements: ...Strict: 1. Assigned one-to-one staff keeps the patient under continuous visual observation. 2. Remains within an ordered distance of the patient to decrease the risk of patient injury to self and others ...."

Medical record review on 08/23/07 of Patient #39 revealed the patient was a 44 year old female who was admitted on 08/18/07 at 2200 for acute psychosis on an involuntary commitment order. Review of the psychiatric assessment, made by the Psychiatrist A upon admission, revealed the patient had been transferred from an acute care hospital where she was treated for lithium toxicity from 08/05-18/07.

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A 392	Continued From page 47 Review of the Fall Risk Assessment that was completed on 08/19/07 (untimed) revealed the patient's fall risk level was "13 ...at risk for falls ..." Review of "Safety Precautions Order" written by Psychiatrist B on 08/19/07 at 0108 revealed, "Safety Precaution Level: Strict (Thought processes fragmented, pt [patient] physically very frail, very unsteady gait." Review of RN C's notes dated 08/19/07 at 0150 (at time of admission to the inpatient nursing unit) revealed, "Pt ...also has unsteady gait c (with) fall risk score of 13 ...."Review of nursing documentation dated 08/19/07 at 0230 revealed, "Pt was dizzy c (with) unsteady gait ..." Review of RN A's (medication nurse) note dated 08/19/07 at 1205 revealed, "...Pacing halls, running at times...Pt. stumbled into wall r/t (related to) unsteady gait and untied shoe strings and bumped R (right) orbital @ eyebrows..." Review of RN A's note dated 08/19/07 at 1500 revealed, "Continues to pace in and out of hall, rooms, day room, timeout room, bathroom...Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2 bruises noted to L forehead c (with) slight swelling @ that time...(Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head...Continued to roam in and out of room, hallway, timeout room, bathroom....Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415....1:1	A 392		

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staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of Geri-Chair) for safety of patient. Order given @ 1400...."

Review of CNA (Certified Nursing Assistant) A's documentation dated 08/19/07 at 1505 revealed, "Pt. 1:1 this shift per volunerbility....Pt. would try to go in and out of other peers rooms, trying to touch other patients, attempting to climb walls, each time pt would be redirected by staff. Redirection ineffective. RN notified....After a head hit to the wall, PA notified for injury. Pt. still climbs walls, attempted to run up and down halls. Pt. offered time-out and went in and out of time-out (TO)....Pt opened TO door and walked in c (with) 1:1 staff standing in doorway. Stood in front of wall and fell straight back onto floor..."

Review of CNA B's documentation dated 08/19/07 (untimed) revealed, "Pt strict for vulnerable for harm...had walked into time-out voluntarily with the door open. Staff stood in front of the doorway observing pt. climbing walls and picking at floor. Pt. had been in and out of time-out, all shift. Staff notified RN..."

Observation on 08/22/2007 at 1620 of the timeout room revealed a room with concrete walls and an uncarpeted, hard floor.

Interview with RN A on 08/23/07 at 0900 revealed the nurse came on duty at 0700 on 08/19/07 and was the medication nurse for the day on the unit. Interview revealed the nurse knew Patient #39 was ordered to be on strict observation for vulnerability to harm. Interview revealed the nurse was aware the patient had been identified

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as a falls risk upon admission. Interview revealed the CNA (CNA A) assigned to the patient was instructed to maintain 1:1 observation and keep the patient within arms reach at all times. Interview revealed that since the physician had not designated the distance of observation on the orders, the nursing staff "always assumes the strictest, which is within arms length at all times". Interview revealed the patient's gait was unsteady when the nurse observed the patient at 1000. Interview revealed "unsteady gait puts a patient at risk for falling". Interview revealed "the 1:1 staff had to hold her (patient's) elbow to support her". Interview revealed the patient wandered in and out of the time-out room several times. Interview revealed the timeout room was the same as the seclusion room. Interview revealed the timeout room had unpadded walls and floors that was used as a restrictive intervention to isolate a patient from other patients to ensure the safety of all patients during behavioral outbursts. Interview revealed 1:1 monitoring is usually accomplished by the CNA sitting or standing in the doorway and observing the patient while he is in the timeout room. Interview revealed Patient #39 was not placed in the timeout room as a restrictive intervention, but rather the patient freely wandered in and out of the room. Interview revealed the patient wandered into the timeout room at 1030, at which time she tried to sit on the mattress that was on the floor and bumped her head, resulting in a ½ inch laceration on her right eyebrow. Interview revealed the patient continued to pace and walk the halls accompanied by one, often two, CNAs and the patient was in and out of the timeout room. Interview revealed the patient wouldn't stay in any one place for more than a few seconds at the time and continued to have an unsteady gait.

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Interview revealed the patient's behavior remained unchanged. Interview revealed at 1230 the patient again wandered into the timeout room and "bumped her head" on the wall, resulting in 2 bruises to her left forehead. Interview revealed Psychiatrist D came up to the unit at approximately 1345. Interview revealed Psychiatrist D ordered medical restraints with a Geri-chair with soft restraints to arms and legs at 1400, after seeing the patient walking in the hall with the assistance of two CNAs. Interview revealed the Geri-chair is not something that is often used on the unit, so the nurse called the house supervisor to locate one. Interview revealed that at1405, before the nurse could get the Geri-chair, the patient "fell in the timeout room".

CNA A was unavailable for interview.

Interview with CNA B on 08/23/07 at 0950 revealed CNA A was the primary CNA assigned to Patient #39 on the morning of 08/19/07 but both CNAs worked with the patient. Interview revealed they "split the 1:1, but most of the day we both worked with her". Interview revealed the CNA knew the patient should be within arms length at all times. Interview revealed the CNA knew the patient had been identified as being at risk for a fall and the staff were to try to help prevent a fall. Interview revealed the patient was "very unsteady when she walked". Interview revealed at one point (unsure of exact time) the patient went in to the timeout room and CNA A was "watching her" at which time CNA A called out, "She walked into the wall." Interview revealed "all of this was reported to the nurses". Interview revealed the two CNAs and PA A took the patient to the treatment room to clean her eye

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after she bumped her head in the timeout room. Interview revealed "this behavior went on all day long". Interview revealed the patient was "very unsteady walking in the hall" and both CNAs (one on each side of the patient) walked with her continuously when she was in the hall. Interview revealed the patient went into the timeout room (unsure of time) and "we were standing in the doorway looking at her. She (patient) was standing at the window and turned to come toward us. As she was coming she turned and bumped into the wall and got a knot on her forehead". Interview revealed the distance from the window to the doorway is more than arms length (approximately 8 feet). Interview revealed, "I've never been told you have to be in the timeout room with a patient if they are in there voluntarily. My understanding of the strict arms length is if they are not in the timeout room." Interview revealed the CNAs notified the nurse that the patient had bumped her head. Interview revealed the patient continued to walk and pace in the halls. Interview revealed the CNA did not feel like the patient was safe because "she was still bumping into stuff with two of us watching her ....We reported to (RN A) we have to do something..." Interview revealed a CNA stayed on each side of the patient while she walked in the hall in an effort to "keep her from bumping into stuff ....I would support her elbow when she would let me". Interview revealed the patient again went into the timeout room and CNA A "stood in the door watching her". Interview revealed, "I was taking the trash past the timeout room door and I heard 'Boom'. I looked and she (patient) was on the floor". Interview confirmed the licensed and unlicensed nursing staff on duty on 08/19/07 were aware that Patient #39 had an unsteady gait. Interview revealed the CNA had

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A 392	Continued From page 52 never been told to go into the timeout room with the patient and did not understand the need to be at the patient's side in the timeout room in order to prevent the patient from falling and subsequently suffering injury. Consequently, the nursing staff on duty on 08/19/07 failed to maintain continuous monitoring at arms length of a 44 year old female patient with a known unsteady gait, who had been identified as a falls risk upon admission and who had a physicians order for 1:1 monitoring due to unsteady gait. As a result, the patient sustained 3 injuries on 08/19/07, at 1030, 1230 and 1405, requiring the patient to be transferred to an acute care hospital for emergency treatment.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, observation and staff and physician interviews the hospital's nursing staff failed to: A) supervise and evaluate the care of a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39), and B) assess a change in condition prior to emergency transfer and upon return to the hospital and failed to follow hospital policy to ensure required paperwork for transfer was completed for 1 of 8 sampled patients that were	A 395		

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transferred (#4).

The findings include:

A) Review of current hospital policy #I-38, entitled "Nursing Assessment and Plan of Care" dated 02/26/07, revealed, "The Registered Nurse (RN) ...assesses the patient's immediate needs related to the reason for admission and current health status ...The assessment process continues throughout the patient's hospitalization. The nurse evaluates the patient's physical ...needs to determine the plan for nursing care ....Individualized nursing interventions are based upon the data collected in the nursing assessment ...Interventions are updated and changed as needed and include rationale, frequency, modality, and staff responsibility ...."

Review of current hospital policy #3-11, entitled "Falls, Assessment, Care and Documentation" dated 09/21/05, revealed, "Clinical staff evaluate the factors which place the patient at risk to consider treatment interventions for the prevention of falls. This includes, but is not limited to: ...3. Medication reviews. 4. Increased nursing staff supervision ...."

Review of current hospital policy #3-19, entitled "Safety Precautions" dated 07/02/07, revealed, "(Name of Hospital) employs precautionary measures to protect patients who are at increased risk for harm, including patients who are suicidal, aggressive and/or vulnerable. Assessing the risk of dangerousness or vulnerability is a continuous interdisciplinary process ....For vulnerable patients, other potentially relevant factors for consideration include: ...Falling ....Consideration is given to

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interventions that may reduce the patient's risk for harm prior to initiation of and during the implementation of safety precautions, including but not limited to: ...Consultations (e.g., medical, ...) ...Adaptations to environment ...Safety Precaution Level Procedures and Patient Monitoring Requirements: ...Strict: 1. Assigned one-to-one staff keeps the patient under continuous visual observation. 2. Remains within an ordered distance of the patient to decrease the risk of patient injury to self and others ...."

Medical record review on 08/23/07 of Patient #39 revealed the patient was a 44 year old female who was admitted on 08/18/07 at 2200 for acute psychosis on an involuntary commitment order. Review of the psychiatric assessment, made by the Psychiatrist A upon admission, revealed the patient had been transferred from an acute care hospital where she was treated for lithium toxicity from 08/05-18/07.

Review of the Fall Risk Assessment that was completed on 08/19/07 (untimed) revealed the patient's fall risk level was "13 ...at risk for falls ..."

Review of "Safety Precautions Order" written by Psychiatrist B on 08/19/07 at 0108 revealed, "Safety Precaution Level: Strict (Thought processes fragmented, pt [patient] physically very frail, very unsteady gait."

Review of RN C's notes dated 08/19/07 at 0150 (at time of admission to the inpatient nursing unit) revealed, "Pt ...also has unsteady gait c (with) fall risk score of 13 ...."Review of nursing documentation dated 08/19/07 at 0230 revealed, "Pt was dizzy c (with) unsteady gait ..."

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Review of Psychiatrist C's (primary psychiatrist on call) progress note dated 08/19/07 at 1000 revealed, "Called by staff. Pt. grossly psychotic ...She is agitated, walking halls, manic ....She is on 1:1 for vulnerability (one staff member to observe patient at all times)."

Review of RN A's (medication nurse) note dated 08/19/07 at 1205 revealed, "Actively hallucinating entire shift to present. Pacing halls, running at times ...(Psychiatrist C) paged and notified of situation at 0915. Orders to give Risperdal 2 mg (milligrams) m-tab (an antipsychotic medication) and Benedryl 50 mg (an antihistamine medication) x 1 (once). Prior to this, @ 0800 med (medication) pass pt. put Seroquel (an antipsychotic medication) in mouth ...and spit it out p (after) leaving med line (place where patients receive medication). Attempting to walk out of locked exit doors. Touching other patients and staff. Redirected to time-out and encouraged to lay down s (without) success. Remains unoriented x 4 (disoriented to person, place, time and situation). (Psychiatrist C) contacted again c (with) orders to give Ativan 2 mg (given @ 1130); and call back in 1 hour c (with) results. Pt. stumbled into wall r/t (related to) unsteady gait and untied shoe strings and bumped R (right) orbital @ eyebrows. Scant amount of blood noted which was cleaned by writer to reveal a ½ inch laceration. PA (physician ' s assistant) notified (PA A) who assessed pt c (with) no new orders given. Pupils reactive to light and equal. 0 (no) c/o (complaints of) pain, 0 swelling, bruising. Remains unoriented x 4 (0 change from baseline). Will continue to monitor effectiveness of Ativan."

Medical record review revealed no documentation

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by PA A of an assessment of patient or evaluation/modification of treatment plan following the injury the patient sustained at 1030.

Review of Psychiatrist D's (psychiatrist 2nd on call) progress note dated 08/19/07 at 1400 revealed, "Pt extremely agitated the whole a.m. and presently ...she is 1:1 but is confused; restless; walking or running away from the staff; fell several times that resulted in bruises; had several meds - not effective/sufficient to protect pt from injury; will start medically related restraints in Geri-chair c (with) the table top and soft restraints on wrists and ankles."

Review of CNA (Certified Nursing Assistant) A's documentation dated 08/19/07 at 1505 revealed, "Pt. 1:1 this shift per volunerbility. Pt. observed within arms length distance @ all times. Pt. would try to go in and out of other peers rooms, trying to touch other patients, attempting to climb walls, each time pt would be redirected by staff. Redirection ineffective. RN notified. PRN (as needed medication) given per (Psychiatrist C) on call. Pt would still try to go in other rooms and still attempted to climb walls. After a head hit to the wall, PA notified for injury. Pt. still climbs walls, attempted to run up and down halls. Pt. offered time-out and went in and out of time-out (TO). Pt. would take back out of TO and try to pick up objects out of floor that wasn't there. Pt opened TO door and walked in c (with) 1:1 staff standing in doorway. Stood in front of wall and fell straight back onto floor. RN notified immediately, who notified a PA and other proper precautions ...."

Review of CNA B's documentation dated 08/19/07 (untimed) revealed, "Pt strict for vulnerable for harm, had been exhibiting bizarre

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behavior this shift, had walked into time-out voluntarily with the door open. Staff stood in front of the doorway observing pt. climbing walls and picking at floor. Pt. had been in and out of time-out, all shift. Staff notified RN, who notified the on-call doctor (Psychiatrist C) of pts. behavior, Dr. wrote order for pt. to have prn (as needed medication), pt. continued climbing walls and bumped head. PA was notified, pt went back on the hall, running up and down hall, staff made many attempts to redirect with no success. Pt. went in time-out room on her on with 1:1 following. Staff heard a thump and notified RN and staff ran in to assist. Where RN and PA took over and assessed pt. Vital signs were taken."

Review of RN A's note dated 08/19/07 at 1500 revealed, "Patient continues to remain actively hallucinating p (after) Ativan 2 mg given @ 1130 per (Psychiatrist C)'s orders. (Required much encouragement to take Ativan). Continues to pace in and out of hall, rooms, day room, timeout room, bathroom. Requiring constant redirection from 1:1 staff. Yelling @ times but speech mainly remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead on wall. Writer assessed forehead @ 1220. 2 bruises noted to L forehead c (with) slight swelling @ that time and notified PA. (PA A) assessed pt c (with) 0 new orders. 0 c/o pain. Remains unoriented to person, place, time, situation. (0 change from baseline). Assisted to dining room where pt. refused lunch and drank 20 cc (milliliters) of tea. (Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head and

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that PA had been contacted c (with) appropriate paper work started. Orders given to give Zyprexa 5 mg (Zydis) (an antipsychotic medication) x 1. Zyprexa Zydis 5 mg given @ 1310. Continued to roam in and out of room, hallway, timeout room, bathroom. Becoming louder c (with) same speech as above present. Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415. Both RNs (writer and [RN B]) into room c (with) 3 CNA staff) ...1:1 staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of Geri-Chair) for safety of patient. Order given @ 1400. Patient laying supine in floor p (after) fall @ 1405 continuing to have flight of ideas, c (with) word salad becoming almost impossible to understand verbally. Words ending in a moan as if in pain. Large amount of swelling noted on physical examination to back of head. Moaning in agony upon touch ..."

Medical record review revealed no documentation by PA A of an assessment of patient or evaluation/modification of treatment plan following the injury the patient sustained at 1230.

Review of a physician's telephone order dated 08/19/07 at 0935 (and signed by Psychiatrist C on 08/19/07) revealed, "Give Risperdal m-tab 2 mg po (by mouth) x 1 now and Benedryl 50 mg po x 1 now. - psychosis". Review of the medication administration record (MAR) revealed Risperdal m-tab 2mg and Benedryl 50 mg were both given by mouth at 1000.

Review of a physician's telephone order (given by Psychiatrist C) dated 08/19/07 at 1125 revealed,

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"Give Ativan 2 mg po x 1 now. Call Dr. back in 1 hr (hour) c (with) results of PRN." Review of the MAR revealed Ativan 2 mg was given by mouth at 1130.

Review of a physician's telephone order (given by Psychiatrist C) dated 08/19/07 at 1300 revealed, "Give Zyprexa Zydis 5 mg PO x 1 now - psychosis." Review of the MAR revealed Zyprexa Zydis 5 mg was given by mouth at 1310.

Observation on 08/22/2007 at 1620 of the timeout room revealed a room with concrete walls and an uncarpeted, hard floor.

Interview with RN A on 08/23/07 at 0900 revealed the nurse came on duty at 0700 on 08/19/07 and was the medication nurse for the day on the unit. Interview revealed the nurse knew Patient #39 was ordered to be on strict observation for vulnerability to harm. Interview revealed the nurse was aware the patient had been identified as a falls risk upon admission. Interview revealed the CNA (CNA A) assigned to the patient was instructed to maintain 1:1 observation and keep the patient within arms reach at all times. Interview revealed that since the physician had not designated the distance of observation on the orders, the nursing staff "always assumes the strictest, which is within arms length at all times". Interview revealed the nurse first observed Patient #39 at approximately 0730, at which time the patient's gait was "more steady" than it was later in the morning. Interview revealed the patient's gait was unsteady when the nurse observed the patient at 1000. Interview revealed "unsteady gait puts a patient at risk for falling". Interview revealed "the 1:1 staff had to hold her (patient's) elbow to support her". Interview

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revealed the patient was constantly pacing and walking in the hall and tried to enter any open room. Interview revealed the 1:1 staff continually walked with the patient in the hall and had to redirect the patient frequently. Interview revealed the patient wandered in and out of the time-out room several times. Interview revealed the timeout room was the same as the seclusion room. Interview revealed the timeout room had unpadded walls and floors that was used as a restrictive intervention to isolate a patient from other patients to ensure the safety of all patients during behavioral outbursts. Interview revealed Patient #39 was not placed in the timeout room as a restrictive intervention, but rather the patient freely wandered in and out of the room. Interview revealed Psychiatrist C was on the unit and saw the patient at approximately 0900. Interview revealed at 0930-1000 the nurse discovered the patient had not swallowed the morning dose of Seroquil (an antipsychotic medication that had been given at 0800). Interview revealed the nurse called Psychiatrist C at approximately 1000 to report the patient's behavior of "pacing the halls, trying to climb the walls, poor articulation, nonstop talking, and word salad" and the fact that the patient had not swallowed her Seroquil. Interview revealed Psychiatrist C ordered Risperdal 2mg and Benedryl 50 mg to be given then, which the nurse gave at 1000. Interview revealed the patient wandered into the timeout room at 1030, at which time she tried to sit on the mattress that was on the floor and bumped her head, resulting in a ½ inch laceration on her right eyebrow. Interview revealed PA A was on the unit making rounds and he "came and looked at the laceration". Interview revealed a Band-Aid was applied to the laceration and no new orders were received. Interview revealed the patient

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continued to pace and walk the halls accompanied by one, often two, CNAs and the patient was in and out of the timeout room. Interview revealed the patient wouldn't stay in any one place for more than a few seconds at the time and continued to have an unsteady gait. Interview revealed the patient's behavior remained unchanged and the nurse notified Psychiatrist C of this fact at 1130, at which time Ativan 2mg was ordered and given to the patient. Interview revealed Psychiatrist C did not come assess the patient. Interview revealed at 1230 the patient again wandered into the timeout room and "bumped her head" on the wall, resulting in 2 bruises to her left forehead. Interview revealed PA A assessed the patient immediately after the second "bump" and no new orders were received. Interview revealed the nurse called Psychiatrist C again at 1310 to report the patient's behavior had not changed, at which time Zyprexa 5mg was ordered and given to the patient. Interview revealed the Zyprexa was given in an effort to "slow her down ...to stop the psychosis". Interview revealed Zyprexa commonly causes drowsiness and "kicks in in about 30-45 minutes, based on what I've seen". Interview revealed, "We were keeping an eye on her." Interview revealed Psychiatrist C did not come assess the patient. Interview revealed Psychiatrist D came up to the unit at approximately 1345. Interview revealed Psychiatrist D ordered medical restraints with a Geri-chair with soft restraints to arms and legs at 1400, after seeing the patient walking in the hall with the assistance of two CNAs. Interview revealed the Geri-chair is not something that is often used on the unit, so the nurse called the house supervisor to locate one. Interview revealed that at1405, before the nurse could get the Geri-chair, the patient "fell in the timeout

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room". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS.

CNA A was unavailable for interview.

Interview with CNA B on 08/23/07 at 0950 revealed CNA A was the primary CNA assigned to Patient #39 on the morning of 08/19/07 but both CNAs worked with the patient. Interview revealed they "split the 1:1, but most of the day we both worked with her". Interview revealed the CNA knew the patient should be within arms length at all times. Interview revealed the CNA knew the patient had been identified as being at risk for a fall and the staff were to try to help prevent a fall. Interview revealed the patient was "very unsteady when she walked". Interview revealed the patient was constantly in and out of her room and the bathroom and was "still very unsteady". Interview revealed the patient's gait was "real wobbly ...it was like she was overstepping her steps ...she was bumping into the walls ...looked like she was trying to walk up steps". Interview revealed it took both of the CNAs to assist the patient use the bathroom because they had to "hold her up for her to get her clothes down". Interview revealed at one point (unsure of exact time) the patient went in to the timeout room and CNA A was "watching her" at which time CNA A called out, "She walked into the wall." Interview revealed "all of this was reported to the nurses". Interview revealed the two CNAs and PA A took the patient to the treatment room to clean her eye after she bumped her head in the timeout room. Interview revealed the patient would not sit still in the treatment room but they "did manage to get a

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Band-Aid on her eyebrow". Interview revealed the PA asked the CNA if it had been determined why the patient's speech was so slurred and why she was so unsteady. Interview revealed "this behavior went on all day long". Interview revealed the patient was "very unsteady walking in the hall" and both CNAs (one on each side of the patient) walked with her continuously when she was in the hall. Interview revealed the patient went into the timeout room (unsure of time) and "we were standing in the doorway looking at her. She (patient) was standing at the window and turned to come toward us. As she was coming she turned and bumped into the wall and got a knot on her forehead". Interview revealed the distance from the window to the doorway is more than arms length (approximately 8 feet). Interview revealed, "I've never been told you have to be in the timeout room with a patient if they are in there voluntarily. My understanding of the strict arms length is if they are not in the timeout room." Interview revealed the CNAs notified the nurse that the patient had bumped her head. Interview revealed the PA came and looked at the bump on the patient's head and said "you can see this will be a bruise and bump". Interview revealed the patient continued to walk and pace in the halls. Interview revealed the CNA did not feel like the patient was safe because "she was still bumping into stuff with two of us watching her ....We reported to (RN A) we have to do something. (RN A) called the psychiatrist". Interview revealed a CNA stayed on each side of the patient while she walked in the hall in an effort to "keep her from bumping into stuff ....I would support her elbow when she would let me". Interview revealed at one point when the CNA tried to redirect the patient from entering another patient's room the patient swung and tried to hit the CNA.

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Interview revealed when the patient swung at the staff member she was unsteady so they "held her so she wouldn't fall". Interview revealed the patient again went into the timeout room and CNA A "stood in the door watching her". Interview revealed, "I was taking the trash past the timeout room door and I heard 'Boom'. I looked and she (patient) was on the floor". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS.

Interview with PA A on 08/23/07 at 1100 revealed the PA was on the unit on the morning of 08/19/07 because he had to do admission physical assessments on several newly admitted patients, including Patient #39. Interview revealed the PA observed the patient in the hall "with two CNAs with her at all times". Interview revealed the patient's gait was "a little unsteady with a jumpy kind of walk". Interview revealed the patient would "miss a step now and then and would have to regain her balance". Interview revealed the PA was reviewing patient charts (unsure of time) when "the nurse told me she (patient) hit her head on the wall and had cut her left eyebrow ....I looked at it and put a Band-Aid on it." Interview revealed the nursing staff told the PA the patient had an unsteady walk and bumped her head into the wall. Interview revealed the PA did not adjust the treatment plan at that time or notify his supervising physician of the patient's condition. Interview revealed about 1-1 ½ hours later "the nurse told me she bumped her head again and I went to the timeout room and looked at her head". Interview revealed the patient's forehead was "maybe a little reddened" from the bump. Interview revealed the PA did not adjust

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the treatment plan at that time or notify his supervising physician of the patient's condition. Interview revealed the PA then left the unit for a while until the nurse called him back (unsure of time) and said "come right away". Interview revealed the nurse report the patient had fallen backwards and hit her head on the floor in the timeout room. Interview revealed the PA and Psychiatrist C arrived to the timeout room at the same time. Interview revealed they attended to the patient until EMS arrived and transported the patient to an acute care hospital's emergency department. Interview revealed only a psychiatrist can order "restrictive measures". Interview revealed the PA had not requested the nursing staff to call the psychiatrist after either of the head bumps.

Telephone interview with Psychiatrist C on 08/23/07 at 1115 revealed the psychiatrist had been on staff at the hospital for one week. Interview revealed the psychiatrist was the primary on call psychiatrist for the hospital on 08/19/07. Interview revealed the nurse had notified the psychiatrist in the morning (unsure of time) that Patient #39 had not swallowed her morning dose of Seroquil and the patient was very agitated and was exhibiting psychotic behavior. Interview revealed the psychiatrist ordered Risperdal M-tab to be given at that time. Interview revealed the nurse called again an hour to hour and a half later and said the patient was still very agitated and wouldn't stop walking. Interview revealed the psychiatrist then ordered Benedryl to be given. Interview revealed that sometimes Risperdal and Benedryl are ordered to be given at the same time for acute psychosis, but the psychiatrist did not order it that way in this case because the patient was very small and thin.

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Interview revealed the nurse called the psychiatrist again about one hour later and said the patient was still very agitated and was crawling on the floor. Interview revealed the nurse then said the patient had laid on the mattress in the timeout room and bumped her head on the wall. Interview revealed the "nurse said something like she had stumbled and hit her head." Interview revealed the information related to the incident was "presented more like she tripped and bumped her head". Interview revealed the nurse did not report that the patient had an unsteady gait. Interview revealed the psychiatrist was aware the PA had seen the patient after the bump and if he had concerns he should have called his supervising physician, who is an internist. Interview revealed at that time the psychiatrist ordered for the patient to receive Ativan. Interview revealed the nurse called again about 1 ½ hours later and said the patient was restless and walking around agitated with the 1:1 CNA having to walk up and down the hall with her. Interview revealed "agitated was the word they kept using". Interview revealed, "I called (Psychiatrist D - 2nd on call that day) to discuss what else we could give her (patient)". Interview revealed the psychiatrist then ordered for the patient to be given Zyprexa. Interview revealed the psychiatrist knew that Psychiatrist D was going to be making rounds on the unit soon after their conversation. Interview revealed the Psychiatrist C was on another unit when she "heard them say they want a PA right now on the women's ward". Interview revealed the psychiatrist went to the women's ward at that time and the patient was laying on the floor in the treatment room. Interview revealed "we assessed her and sent her to the hospital".

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Telephone interview with Psychiatrist D on 08/25/07 at 0915 revealed she was the 2nd on call psychiatrist on 08/19/07 and was therefore making rounds on the units. Interview revealed Psychiatrist C had called her at some point that morning (unsure of time) and discussed Patient #39 with her. Interview revealed they discussed the level of the patient's agitation and possible medication plans for treatment. Interview revealed she told her the patient was on 1:1 monitoring for vulnerability and had "already fallen" but didn't say why. Interview revealed that Psychiatrist C did not ask her to go see the patient, but rather that she knew Psychiatrist D would be making rounds on the unit soon anyway. Interview revealed nursing staff had not notified her of the patient's condition at any point, because they were communicating with Psychiatrist C. Interview revealed Psychiatrist D went to the unit at approximately 1345 for rounds. Interview revealed, "I saw the patient walking in the hall with 2 staff members." Interview revealed the patient had an unsteady gait. Interview revealed, "When I saw what was going on I said the only way to prevent her from falling was to put her in the Geri-chair." Interview revealed she felt the Geri-chair with soft restraints was necessary to protect the patient. Interview revealed after the psychiatrist saw the patient, she thought "it was an accident waiting to happen ....they (the staff) knew it ...they were aware of it". Interview revealed the patient fell before the nursing staff could execute the order for medical restraints. Interview revealed that medical restraints are unusual on a psychiatric unit, but they can be used there and are sometimes necessary. Interview revealed an unsteady gait is uncommon for a patient with acute psychosis. Interview revealed these patients' movements are often

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very coordinated "unless they have too much medication or something". Interview revealed a PA with concerns about a patient could contact his supervising physician (an internist) or the psychiatrist for guidance.

Interview with administrative nursing staff on 08/24/07 at 1530 revealed the nursing staff present at the time of the fall had notified the administrator at home. Interview revealed a Serious Incident Notification had been done by the house supervisor, which prompted an internal investigation into the incident. Interview revealed the investigation included a review of the medical record and related incident report, as well as staff interviews. Interview revealed no Root Cause Analysis had been initiated. Interview revealed the administrator of the division and the nurse manager (both present at interview) both felt the care and monitoring provided for the patient on 08/19/07 had been appropriate. Interview revealed after reviewing the information obtained during the internal investigation, including the medical record, the administrator and nurse manager's main concern was that the nurse had called 911 directly, rather than following the hospital's procedure of calling the in house operator. Interview revealed the nurse manager thought that the patient's treatment plan was appropriately adjusted because the nursing staff maintained 1:1 monitoring and called the physician for medication adjustments throughout the shift on which the fall occurred.

Consequently, there was no coordination of nursing, medical and psychiatric care for a 44 year old female patient with a known unsteady gait. As a result, the patient sustained 3 injuries on 08/19/07, at 1030, 1230 and 1405, requiring

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A 395	Continued From page 69 the patient to be transferred to an acute care hospital for emergency treatment. B) Review of the hospital's "Nursing Assessment and Plan of Care" policy effective February 26, 2007 reveals "The Registered Nurse (RN), at the time of admission, assesses the patient's immediate needs related to the reason for admission and current health status, and develops a plan to meet those needs. The assessment process continues throughout the patient's hospitalization. The nurse evaluates the patient's physical, psychological, educational, social, nutritional, economic and spiritual needs to determine the plan for nursing care .....Ongoing assessments are documented in the progress notes or other assessment forms as the patient's status changes." Review of the hospital's "Medical Transfer to Other Hospitals, Referral" policy effective September 20, 2006 reveals "II. B. 1. Every attempt is made by the attending physician/designee to contact the receiving facility about the transfer. If there are difficulties or delays in contacting the receiving facility, this is documented in the medical record. If it is an emergency, call 911 to transport by EMS (emergency transport), and inform the receiving hospital of the transfer. 2. The attending physician should attempt to contact the receiving physician by telephone to ensure that hand-off communication has been provided. Documentation of such contact and an overview of the discussion should be charted in the progress section of the chart. Note: If unable to contact the receiving physician, document such efforts. III. A. Physician writes transfer order on physician's order form. E. Complete the Off	A 395		

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Campus Transfer Summary/Consult Referral (Send one copy to the receiving facility ...and file the original in the miscellaneous section of the chart)."

Closed record review on 08/23/2007 of Patient #4 revealed a 41 year-old female that was admitted 07/26/2007 with major depression and discharged 07/30/2007. Record review revealed the patient was transferred from an acute hospital (Hospital C) emergency department (ED) due to a suicide attempt. Review of records from Hospital C's ED revealed a pregnancy test dated 07/25/2007 was negative. Review of the physician's history and physical exam dictated 07/28/2007 revealed the patient's "LMP (last menstrual period): patient has her menses and her periods are irregular." Nursing progress notes dated 07/29/2007 at 1225 documented "Patient was in restroom this AM and came out requesting help. Patient had bright red blood running down both inner thighs. Patient stated 'I think I had a miscarriage.' Patient reports a history of miscarriages. Patient evaluated by PA (Physician's Assistant). PA called EMS (emergency transport). EMS transported to (acute Hospital B)." Review of the record revealed the next nursing entry was documented on 07/29/2007 at 2020. Review of the vital sign flow sheet revealed documentation of the patient's vital signs at 0800 and 2000. Review of the record revealed no assessment of the vital signs documented when the patient reported the bleeding and no documented assessment of the amount of blood loss, duration of bleeding, assessment of last menstrual period or level of consciousness. Further review of the record revealed no physician's order to transfer the patient and no documentation of an examination by the PA. The review revealed no

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documentation of what time the patient was transferred or returned to the hospital, and no documentation of the patient's condition upon return from the acute care hospital's emergency department.

Review of the transferring hospital's (Hospital B) emergency department record revealed Patient #4 arrived via EMS on 07/29/2007 at 1107 with a chief complaint of "spotting times four days, increased vaginal bleeding today, negative pregnancy test on 07/25/2007." The record revealed the patient was accompanied by a CNA (certified nursing assistant). Record review revealed orthostatic blood pressures, lab studies and a pelvic exam were completed in the emergency department. Review of the ED physician's documentation revealed a diagnosis of "dysmennorhea" and the patient was discharged. Further review of the record failed to reveal a time of discharge.

Interview on 08/24/2007 at 0830 with the PA that was working on 07/29/2007 when the patient was transferred (PA B) revealed he was asked to come check the patient. He stated "She was in the bathroom stall. Blood was flowing out of her ...not pooling ...sanitary pad was soaked. She said it had just started and was not normal for her. She was afraid. She said she thought she was having a miscarriage. I did not do a vaginal exam at that time. I felt she needed to go out urgently. There was a physician on call. I did not feel she needed to be delayed. She needed to be in an emergency room ....needed immediate referral to specialty services. I asked telecom to call EMS ....I don't remember if I completed the transfer paperwork. It can't be found ..... I did not write an order to transfer the patient .... I did not

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A 395	Continued From page 72 call the ED physician. I did call the ED nurse. I did not document that I called the ED nurse .... For the past year, we don't have a good relationship with (Hospital B ED). The physicians won't talk with us. They are worried that we won't take the patients back. It is a waste of time trying to call them." Interview on 08/24/2007 at 0935 with the RN that was working on 07/29/2007 when the patient was transferred (RN D) revealed he remembered the patient. The nurse stated that the patient thought she was having a miscarriage and that she had "bright red blood running down her legs." The nurse stated that there was no pooling of blood and described the amount as a "trickle." The nurse stated he notified the PA B, who saw the patient. The interview revealed the PA called 911 for emergency transport. The interview revealed that the PA usually completes the transfer paperwork. The nurse stated that he did not call Hospital B's ED to give a report and that the required transfer paperwork was not completed. The nurse reviewed the record and confirmed there was no evidence of vital signs taken when the bleeding was reported and prior to the patient ' s emergency transfer. The nurse confirmed there was no documentation of an assessment of the patient's condition prior to transfer or upon return to the hospital from the ED.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.	A 396		

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A 396	Continued From page 73 This STANDARD is not met as evidenced by: Based on hospital policy review, medical record reviews, observations and staff and physician interviews the hospital's nursing staff failed to update the nursing care plan of a patient with repeated injuries related to a known unsteady gait for 1 of 1 sampled patients with an unsteady gait (#39). The findings include Review of current hospital policy #I-38, entitled "Nursing Assessment and Plan of Care" dated 02/26/07, revealed, "The Registered Nurse (RN) ...assesses the patient's immediate needs related to the reason for admission and current health status, and develops a plan to meet those needs. The assessment process continues throughout the patient's hospitalization. The nurse evaluates the patient's physical...needs to determine the plan for nursing care. ...RNs incorporate nursing interventions into the interdisciplinary treatment plan ....Patient problems/needs are prioritized. The problem(s) which result in the patient being hospitalized initially or result in continuing hospitalization (related to the impaired safety of the patient ...) is (are) the primary problem(s) and are included in the nursing plan of care. Problems that impact the patient's lifestyle significantly ...and/or require a number of treatment interventions, including additional monitoring ...are also addressed in the nursing plan of care. When nursing identifies problems that only require nursing care, they are also addressed in the nursing plan of care ....Objectives/goals are written ...Individualized nursing interventions are based upon the data collected in the nursing assessment	A 396		

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A 396	Continued From page 74 ...Interventions are updated and changed as needed and include rationale, frequency, modality, and staff responsibility ....The patient's success at meeting objectives, the nursing care provided, and assessment of its effectiveness are documented in regular ...nursing treatment/progress notes ...After the Initial Nursing Plan of Care is completed, the nursing plan of care is updated any time a problem is identified ....The RN writes a progress note summarizing the problem, the care provided, the patient's response to care, and the change in the problem status ..." Medical record review on 08/23/07 of Patient #39 revealed the patient was a 44 year old female who was admitted on 08/18/07 at 2200 for acute psychosis on an involuntary commitment order. Review of the psychiatric assessment, made by the Psychiatrist A upon admission, revealed the patient had been transferred from an acute care hospital where she was treated for lithium toxicity from 08/05-18/07. Review of the Fall Risk Assessment that was completed on 08/19/07 (untimed) revealed the patient's fall risk level was "13 ...at risk for falls ..." Review of "Safety Precautions Order" written by Psychiatrist B on 08/19/07 at 0108 revealed, "Safety Precaution Level: Strict (Thought processes fragmented, pt [patient] physically very frail, very unsteady gait." Review of RN C's notes dated 08/19/07 at 0150 (at time of admission to the inpatient nursing unit) revealed, "Pt ...also has unsteady gait c (with) fall risk score of 13 ...." Review of nursing documentation dated 08/19/07 at 0230 revealed,	A 396		

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A 396	Continued From page 75 "Pt was dizzy c (with) unsteady gait ..." Medical record review revealed documentation of a nursing care plan entitled "At Risk for Falls" dated 08/19/07 (untimed) that was initiated by RN C, the nurse that admitted the patient to the unit during the third shift of 08/18/07. Record review revealed the nursing care plan had not been updated since this admission care plan. Review of Psychiatrist C's (primary psychiatrist on call) progress note dated 08/19/07 at 1000 revealed, "Called by staff. Pt. grossly psychotic ...She is agitated, walking halls, manic ....She is on 1:1 for vulnerability (one staff member to observe patient at all times)." Review of RN A's (medication nurse) note dated 08/19/07 at 1205 revealed, "Actively hallucinating entire shift to present. Pacing halls, running at times ...(Psychiatrist C) paged and notified of situation at 0915. Orders to give Risperdal 2 mg (milligrams) m-tab (an antipsychotic medication) and Benedryl 50 mg (an antihistamine medication) x 1 (once). Prior to this, @ 0800 med (medication) pass pt. put Seroquel (an antipsychotic medication) in mouth ...and spit it out p (after) leaving med line (place where patients receive medication). Attempting to walk out of locked exit doors. Touching other patients and staff. Redirected to time-out and encouraged to lay down s (without) success. Remains unoriented x 4 (disoriented to person, place, time and situation). (Psychiatrist C) contacted again c (with) orders to give Ativan 2 mg (given @ 1130); and call back in 1 hour c (with) results. Pt. stumbled into wall r/t (related to) unsteady gait and untied shoe strings and bumped R (right) orbital @ eyebrows. Scant amount of blood	A 396		

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noted which was cleaned by writer to reveal a ½ inch laceration. PA (physician's assistant) notified (PA A) who assessed pt c (with) no new orders given. Pupils reactive to light and equal. 0 (no) c/o (complaints of) pain, 0 swelling, bruising. Remains unoriented x 4 (0 change from baseline). Will continue to monitor effectiveness of Ativan."

Medical record review revealed no documentation by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1030.

Review of Psychiatrist D's (psychiatrist 2nd on call) progress note dated 08/19/07 at 1400 revealed, "Pt extremely agitated the whole a.m. and presently ...she is 1:1 but is confused; restless; walking or running away from the staff; fell several times that resulted in bruises; had several meds - not effective/sufficient to protect pt from injury; will start medically related restraints in Geri-chair c (with) the table top and soft restraints on wrists and ankles."

Review of CNA (Certified Nursing Assistant) A's documentation dated 08/19/07 at 1505 revealed, "Pt. 1:1 this shift per volunerbility. Pt. observed within arms length distance @ all times. Pt. would try to go in and out of other peers rooms, trying to touch other patients, attempting to climb walls, each time pt would be redirected by staff. Redirection ineffective. RN notified. PRN (as needed medication) given per (Psychiatrist C) on call. Pt would still try to go in other rooms and still attempted to climb walls. After a head hit to the wall, PA notified for injury. Pt. still climbs walls, attempted to run up and down halls. Pt. offered time-out and went in and out of time-out (TO). Pt.

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would take back out of TO and try to pick up objects out of floor that wasn't there. Pt opened TO door and walked in c (with) 1:1 staff standing in doorway. Stood in front of wall and fell straight back onto floor. RN notified immediately, who notified a PA and other proper precautions...."

Review of CNA B's documentation dated 08/19/07 (untimed) revealed, "Pt strict for vulnerable for harm, had been exhibiting bizarre behavior this shift, had walked into time-out voluntarily with the door open. Staff stood in front of the doorway observing pt. climbing walls and picking at floor. Pt. had been in and out of time-out, all shift. Staff notified RN, who notified the on-call doctor (Psychiatrist C) of pts. behavior, Dr. wrote order for pt. to have prn (as needed medication), pt. continued climbing walls and bumped head. PA was notified, pt went back on the hall, running up and down hall, staff made many attempts to redirect with no success. Pt. went in time-out room on her on with 1:1 following. Staff heard a thump and notified RN and staff ran in to assist. Where RN and PA took over and assessed pt. Vital signs were taken."

Review of RN A's note dated 08/19/07 at 1500 revealed, "Patient continues to remain actively hallucinating p (after) Ativan 2 mg given @ 1130 per (Psychiatrist C)'s orders. (Required much encouragement to take Ativan). Continues to pace in and out of hall, rooms, day room, timeout room, bathroom. Requiring constant redirection from 1:1 staff. Yelling @ times but speech mainly remains pressured, rapid, difficult to understand @ times. Attempted to hit 1:1 staff @ 1330 (CNA A). Flight of ideas and word salad present. Walking into timeout room and sat down on mattress. Pt again hit L (left) inside of forehead

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on wall. Writer assessed forehead @ 1220. 2 bruises noted to L forehead c (with) slight swelling @ that time and notified PA. (PA A) assessed pt c (with) 0 new orders. 0 c/o pain. Remains unoriented to person, place, time, situation. (0 change from baseline). Assisted to dining room where pt. refused lunch and drank 20 cc (milliliters) of tea. (Psychiatrist C) contacted @ 1230 c (with) report given of situation including fact that pt. unsteady gait, stumbling, hit head and that PA had been contacted c (with) appropriate paper work started. Orders given to give Zyprexa 5 mg (Zydis) (an antipsychotic medication) x 1. Zyprexa Zydis 5 mg given @ 1310. Continued to roam in and out of room, hallway, timeout room, bathroom. Becoming louder c (with) same speech as above present. Walked into timeout room looking @ wall and according to 1:1 staff, (CNA A) pt. fell straight back hitting head on floor @ 1415. Both RNs (writer and [RN B]) into room c (with) 3 CNA staff) ...1:1 staff reports unable to catch pt. before fall. Prior to fall, (Psychiatrist D) to ward @ 1345 to assess pt. and was in middle of writing orders for medical related restraints to be applied (use of Geri-Chair) for safety of patient. Order given @ 1400. Patient laying supine in floor p (after) fall @ 1405 continuing to have flight of ideas, c (with) word salad becoming almost impossible to understand verbally. Words ending in a moan as if in pain. Large amount of swelling noted on physical examination to back of head. Moaning in agony upon touch ..."

Medical record review revealed no documentation by PA A of an assessment of the patient or evaluation/modification of treatment plan following the injury the patient sustained at 1230.

Observation on 08/22/2007 at 1620 of the timeout

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room revealed a room with concrete walls and an uncarpeted, hard floor.

Interview with RN A on 08/23/07 at 0900 revealed the nurse came on duty at 0700 on 08/19/07 and was the medication nurse for the day on the unit. Interview revealed the nurse knew Patient #39 was ordered to be on strict observation for vulnerability to harm. Interview revealed the nurse was aware the patient had been identified as a falls risk upon admission. Interview revealed the CNA (CNA A) assigned to the patient was instructed to maintain 1:1 observation and keep the patient within arms reach at all times. Interview revealed that since the physician had not designated the distance of observation on the orders, the nursing staff "always assumes the strictest, which is within arms length at all times". Interview revealed the nurse first observed Patient #39 at approximately 0730, at which time the patient's gait was "more steady" than it was later in the morning. Interview revealed the patient's gait was unsteady when the nurse observed the patient at 1000. Interview revealed "unsteady gait puts a patient at risk for falling". Interview revealed "the 1:1 staff had to hold her (patient's) elbow to support her". Interview revealed the patient was constantly pacing and walking in the hall and tried to enter any open room. Interview revealed the 1:1 staff continually walked with the patient in the hall and had to redirect the patient frequently. Interview revealed the patient wandered in and out of the time-out room several times. Interview revealed the timeout room was the same as the seclusion room. Interview revealed the timeout room had unpadded walls and floors that was used as a restrictive intervention to isolate a patient from other patients to ensure the safety of all patients

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during behavioral outbursts. Interview revealed Patient #39 was not placed in the timeout room as a restrictive intervention, but rather the patient freely wandered in and out of the room. Interview revealed Psychiatrist C was on the unit and saw the patient at approximately 0900. Interview revealed at 0930-1000 the nurse discovered the patient had not swallowed the morning dose of Seroquil (an antipsychotic medication that had been given at 0800). Interview revealed the nurse called Psychiatrist C at approximately 1000 to report the patient's behavior of "pacing the halls, trying to climb the walls, poor articulation, nonstop talking, and word salad" and the fact that the patient had not swallowed her Seroquil. Interview revealed Psychiatrist C ordered Risperdal 2mg and Benedryl 50 mg to be given then, which the nurse gave at 1000. Interview revealed the patient wandered into the timeout room at 1030, at which time she tried to sit on the mattress that was on the floor and bumped her head, resulting in a ½ inch laceration on her right eyebrow. Interview revealed PA A was on the unit making rounds and he "came and looked at the laceration". Interview revealed a Band-Aid was applied to the laceration and no new orders were received. Interview revealed the nursing plan of care was not changed. Interview revealed the patient continued to pace and walk the halls accompanied by one, often two, CNAs and the patient was in and out of the timeout room. Interview revealed the patient wouldn't stay in any one place for more than a few seconds at the time and continued to have an unsteady gait. Interview revealed the patient's behavior remained unchanged and the nurse notified Psychiatrist C of this fact at 1130, at which time Ativan 2mg was ordered and given to the patient. Interview revealed Psychiatrist C did not come

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assess the patient. Interview revealed at 1230 the patient again wandered into the timeout room and "bumped her head" on the wall, resulting in 2 bruises to her left forehead. Interview revealed PA A assessed the patient immediately after the second "bump" and no new orders were received. Interview revealed the nursing plan of care was not changed. Interview revealed the nurse called Psychiatrist C again at 1310 to report the patient's behavior had not changed, at which time Zyprexa 5mg was ordered and given to the patient. Interview revealed the Zyprexa was given in an effort to "slow her down ...to stop the psychosis". Interview revealed Zyprexa commonly causes drowsiness and "kicks in in about 30-45 minutes, based on what I've seen". Interview revealed, "We were keeping an eye on her." Interview revealed Psychiatrist C did not come assess the patient. Interview revealed the nursing plan of care was not changed. Interview revealed Psychiatrist D came up to the unit at approximately 1345. Interview revealed Psychiatrist D ordered medical restraints with a Geri-chair with soft restraints to arms and legs at 1400, after seeing the patient walking in the hall with the assistance of two CNAs. Interview revealed the Geri-chair is not something that is often used on the unit, so the nurse called the house supervisor to locate one. Interview revealed that at 1405, before the nurse could get the Geri-chair, the patient "fell in the timeout room". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS. Interview confirmed the nursing plan of care had not been updated since the admission plan of care.

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A 396	Continued From page 82 CNA A was unavailable for interview. Interview with CNA B on 08/23/07 at 0950 revealed CNA A was the primary CNA assigned to Patient #39 on the morning of 08/19/07 but both CNAs worked with the patient. Interview revealed they "split the 1:1, but most of the day we both worked with her". Interview revealed the CNA knew the patient should be within arms length at all times. Interview revealed the CNA knew the patient had been identified as being at risk for a fall and the staff were to try to help prevent a fall. Interview revealed the patient was "very unsteady when she walked". Interview revealed the patient was constantly in and out of her room and the bathroom and was "still very unsteady". Interview revealed the patient's gait was "real wobbly ...it was like she was overstepping her steps ...she was bumping into the walls ...looked like she was trying to walk up steps". Interview revealed it took both of the CNAs to assist the patient use the bathroom because they had to "hold her up for her to get her clothes down". Interview revealed at one point (unsure of exact time) the patient went in to the timeout room and CNA A was "watching her" at which time CNA A called out, "She walked into the wall." Interview revealed "all of this was reported to the nurses". Interview revealed the two CNAs and PA A took the patient to the treatment room to clean her eye after she bumped her head in the timeout room. Interview revealed the patient would not sit still in the treatment room but they "did manage to get a Band-Aid on her eyebrow". Interview revealed the PA asked the CNA if it had been determined why the patient's speech was so slurred and why she was so unsteady. Interview revealed "this behavior went on all day long". Interview revealed	A 396		

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the patient was "very unsteady walking in the hall" and both CNAs (one on each side of the patient) walked with her continuously when she was in the hall. Interview revealed the patient went into the timeout room (unsure of time) and "we were standing in the doorway looking at her. She (patient) was standing at the window and turned to come toward us. As she was coming she turned and bumped into the wall and got a knot on her forehead". Interview revealed the distance from the window to the doorway is more than arms length (approximately 8 feet). Interview revealed, "I've never been told you have to be in the timeout room with a patient if they are in there voluntarily. My understanding of the strict arms length is if they are not in the timeout room." Interview revealed the CNAs notified the nurse that the patient had bumped her head. Interview revealed the PA came and looked at the bump on the patient's head and said "you can see this will be a bruise and bump". Interview revealed the patient continued to walk and pace in the halls. Interview revealed the CNA did not feel like the patient was safe because "she was still bumping into stuff with two of us watching her ....We reported to (RN A) we have to do something. (RN A) called the psychiatrist". Interview revealed a CNA stayed on each side of the patient while she walked in the hall in an effort to "keep her from bumping into stuff ....I would support her elbow when she would let me". Interview revealed at one point when the CNA tried to redirect the patient from entering another patient's room the patient swung and tried to hit the CNA. Interview revealed when the patient swung at the staff member she was unsteady so they "held her so she wouldn't fall". Interview revealed the patient again went into the timeout room and CNA A "stood in the door watching her". Interview

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A 396	Continued From page 84 revealed, "I was taking the trash past the timeout room door and I heard 'Boom'. I looked and she (patient) was on the floor". Interview revealed the nurse, PA and Psychiatrist attended to the patient, who was subsequently transferred to an acute care hospital's emergency department via EMS. Interview revealed the RN had not informed the CNA of a different plan of care during the shift. Consequently, nursing services, medical and psychiatric physicians failed to coordinate the physical and behavioral care needs of Patient #39, 44 year old patient with a diagnosis of psychosis and known unsteady gait. Facility staff failed to adequately supervise the wandering of Patient #39. As a result, Patient #39 sustained 3 injuries on 08/19/07, at 1030, 1230 and 1405, subsequently requiring transfer to an acute care hospital for emergency treatment.	A 396		
A 404	482.23(c) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. This STANDARD is not met as evidenced by: Based on policy and procedure review, open medical record review and staff interviews the hospital staff failed to follow the physician's order	A 404		

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for a medical alert to obtain the patient's blood pressure prior to 45 of 91 administrations of a hypotensive medication for 1 of 21 sampled open records (#45).

The findings include:

Review of the policy "Medication Administration" dated 02/2005 revealed "Medical Alert: any pertinent information about the patient that would alter the routine method of administration of medication/treatment."

Medical record review on 08/24/2007 revealed patient #45 was admitted to the hospital with the diagnosis of paranoid schizophrenia and hypertension and remains hospitalized. Record review of a physician's order dated 05/26/2007 at 1635 revealed "Start Atenolol (medication used to lower the blood pressure) 25 mg (milligram) po (per mouth) BID (twice a day) for hypertension, "MEDICAL ALERT -(hold if pulse< (less) than 70, Systolic < 110 Diastolic <75)." Record review of the Medication Assessment Record Sheets dated 06/2007 and 07/2007 revealed the above order documented with the medical alert. Further review revealed the nursing staff failed 34 out of the 56 times to obtain a blood pressure and pulse prior to administering Atenolol to patient #45 in the month of June. Record review revealed the nurse held the Atenolol at the 0800 am dose on 06/10/2007 due to a low blood pressure. Further review revealed administration of Atenolol at 2000 without documentation of a blood pressure. Review of the MAR dated 07/2007 revealed the nursing staff failed to obtain a blood pressure or pulse prior to administering Atenolol for 11 of 35 doses for the 19 days of July. Record review revealed the physician discontinued the Medical

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A 404	Continued From page 86 Alert for the Atenolol administration on 07/19/2007. Interview on 08/23/2007 at 1300 with the nursing supervisor confirmed the physician had ordered the nursing staff to follow the Medical Alert to monitor the blood pressure and pulse before administering Atenolol. Further interview confirmed the nursing staff had failed to follow the Medical Alert 45 times prior to administration of Atenolol to patient #45.	A 404		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD - DISCHARGE SUMMARY All records must include discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on policy and procedure review, staff interview, physician interview and closed record review, the hospitals medical records department failed to ensure discharge summaries were authenticated /co-authenticated by the individual(s) responsible for 4 of 4 discharge summaries reviewed, completed by Physician T (patient #50, 49, 48 and 51). The findings include: Review of the hospital's "Record Entries,	A 468		

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Quantitative" policy dated 05/25/2007, revealed "Discharge Summary No later than 15 Days (Dictated) No later than 30 Days (Complete)".

Review of the hospital's "Medical Records" policy dated 05/25/2007 revealed, "Entries in the patient record are dated and authenticated... The parts of the medical record that are the responsibility of the medical practitioner are authenticated by him/her."

Interview on 08/24/2007 at 1340 with the Health Information Management Manager revealed the hospital has had an increase in delinquent records since December 2006. The interview revealed in July 2007 the hospital started to use the services of a Locum Tenens Physician to assist in "catching up" on delinquent records by having the physician complete delinquent discharge summaries. The interview revealed Physician T was not the physician responsible for the patients care during the hospitalization for which he is completing the discharge summaries. The interview revealed when the discharge summary is completed and signed by Physician T, the record is considered complete and no co-authentication is required.

Review on 08/24/2007 of the credential file for Physician T revealed, on June 01, 2007 Physician T was approved for privileges through September 30, 2007.

Interview on 08/25/2007 at 1435 with the Clinical Director revealed physicians in the clinical directors' office direct Physician T as to which discharge summaries to complete. The interview revealed Physician T was given a format of what is required to be included in the discharge

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summaries, and given examples of previous discharge summaries. The interview revealed Physician T has not been involved in the patient care of the patients whose discharge summaries he has dictated. The interview revealed there is not a process in place to have the physician responsible for the patients' treatment to review the discharge summary and co-authenticate the entry to verify content.

Record review on 08/25/2007 revealed patient # 50 discharged from the hospital on 02/09/2007 (4 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/16/2007 (5 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T.

Record review on 08/25/2007 revealed patient # 49 discharged from the hospital on 05/11/2007 (1 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 08/13/2007 (3 months after the patients discharge). Review of the discharge summary failed to reveal authentication by Physician T.

Record review on 08/25/2007 revealed patient # 48 discharged from the hospital on 02/09/2007 (4 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/06/2007 (5 months after the patients discharge). Review of the discharge summary failed to reveal co-authentication of the discharge summary by the physician responsible for the patient's treatment during the hospitalization.

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A 468	Continued From page 89 Record review on 08/25/2007 revealed patient # 51 discharged from the hospital on 01/23/2007 (4.5 months prior to Physician T's appointment). Review of the discharge summary revealed Physician T dictated the discharge summary on 07/02/2007 (6 months after the patients discharge). Review of the discharge summary failed to reveal co-authentication of the discharge summary by the physician responsible for the patient's treatment during the hospitalization.	A 468		
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use, and disposal of radioactive materials. This STANDARD is not met as evidenced by: Based on policy and procedure review, review of the radiology log, observation, staff interview and physician interview, the hospital failed to ensure minimal radiation exposure to patients by failing to shield patients during radiation exposure. The findings include: Review of the hospital's Radiology Services Manual, "Operating and Safety Procedure" policy dated 05/31/2007 revealed, "It is our policy to provide the patient, employee, and the public with the appropriate protective lead garment and other	A 536		

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appropriate devices when an exposure is being made. The technologist will always shield the reproductive organs of all children and adults when possible."

Review on 08/24/2007 of the radiology department log dated from August 01- 23, 2007 revealed 95 patient entries, with a total of 347 films obtained, including 33 chest films and 26 KUB/spinal films/abdominal series films, 11 pelvis or hip films and 45 extremity films.

Observation on 08/23/2007 at 1150 revealed radiology department room one with one lead apron. Observation revealed radiology department room two with multiple lead aprons and one lead pelvic shield. Observation revealed one portable X-ray unit, with one lead apron. Observation failed to reveal shielding aprons available for patients with the portable X-ray unit.

Interview on 08/23/2007 at 1200 with the Radiology Manager revealed lead aprons and shields are not used for patients. The interview revealed the manager relies on "Coning and Collimating" to minimize radiation exposure of patients. Continued interview revealed the radiology staff have not routinely shielded patients during X-rays for the past three years. The interview revealed pediatric patients may be shielded with a pelvic apron if it does not interfere with the test being conducted. The interview revealed the pelvic apron is used infrequently. The Manager stated the hospitals policy does require patients to be shielded when shielding does not interfere with testing.

Interview on 08/23/2007 at 1200 with the hospital's Medical Director (the on site Supervisor

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A 536	Continued From page 91 of Radiology Services) revealed the physician is aware of Radiology Department staff not shielding patients during radiation exposure. The interview revealed the physician stated "nobody shields patients. I just had an x-ray (at a different hospital) and they didn't shield me." The interview revealed the radiology department performs X-rays on an average of ten patients per day or 200 patients per month. Continued interview revealed the physician is aware of hospital's policy requiring shielding of patients to reduce unnecessary exposure to radiation. The interview confirmed the hospital's policy is not being followed.	A 536		
A 538	482.26(b)(3) MONITORING RADIATION EXPOSURE Radiation workers must be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure. This STANDARD is not met as evidenced by: Based on policy and procedure review, observation, staff interview and physician interview, the hospital failed to ensure accurate monitoring of employee radiation exposure for 3 of 3 sampled staff (#1, 2 and 3). The findings include: Review of the hospitals Radiology Services "Operating and Safety Procedure" policy dated 05/31/2007 revealed, "Each employee working in	A 538		

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A 538	Continued From page 92 the radiation area will be given a personnel badge ... When not in use, store badges in the office on the hangers provided. The control badge shall also be stored in the same radiation free area in the Secretary's office." Observation on 08/23/2007 at 1210 revealed two radiology staff members wearing personnel monitoring badges. Observation revealed one physician in the Radiology Department wearing a personnel monitoring badge. Observation revealed one control badge on the badge storage board. Observation revealed no employee badges hanging on the board. Interview on 08/23/2007 at 1215 with a Radiology Technician (RT - staff #1) revealed the RT does not store the personnel monitoring badge in the secretaries' office when not working. The interview revealed the RT places the badge in the pocket of her purse at the end of her shift and the RT carries the purse out of the hospital. Interview on 08/23/2007 at 1210 with the Radiology Manager (staff #2) revealed the hospital has three radiology staff members. The interview revealed one staff member was not working this day (staff #3). The interview revealed the staff members badge was not stored on the badge storage board. The interview revealed staff do not store their personnel monitoring badges on the storage board when not working. The interview revealed the Manager was aware of the hospital's policy for storing the personnel monitoring badges on the storage board in the Secretary's office. The interview revealed the Manager was unable to explain why the policy for maintaining the badges was not followed or enforced.	A 538		

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A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on policy and procedure review, open record review and staff interviews the hospital staff failed to follow contact isolation precautions per hospital policy for 2 of 5 sampled records (#45, #15). The findings include: 1. Review of the policy "Resistant Organisms" revised 12/07/2005 revealed "The hospital shall have a plan for detection, prevention, and control of infection and colonization with multiple-antibiotic-resistant organisms, specifically methicillin-resistant staphylococcus aureus (MRSA) and vancomycin-resistant enterocci (VRE) ...The Infection Control Nurse (ICN) receives a copy of each culture report, and assesses it for MRSA and VRE. Action is taken as appropriate ...Contact Precautions are indicated ...b. patients with wounds heavily colonized or infected with MRSA or VRE."	A 749		

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Review of the Infection Control Nurse's job description revealed "Surveillance ...application of infection control policies ....Infection Control and Prevention ...To halt infection transmission through identification and resolution of infection control problems and unsafe work practices."

Medical record review on 08/24/2007 revealed patient #18 was admitted to the hospital on 12/22/2006 with the diagnosis of schizoaffective disorder and remains hospitalized. Record review of a physician assistant's progress note dated 02/14/2007 revealed "Patient having pain from left axilla abscess..large abscess L (left) axilla with erythema tender to palpitation.." Record review of the Medical Clinic Procedure Documentation dated 02/15/2007 revealed "procedure at 0915..I/D (incision and drainage) Abscess Left Axillae. Specimens-#1 C/S (culture and sensitivity) left axilla abscess upper site and #2 mod (moderate) site." Record review of nursing notes dated 02/15/2007 at 1355 revealed "ABD (abdominal) pad was applied to L axilla when dressing had become saturated. Pt (patient) was started on Keflex (antibiotic)." Further record review of nursing notes dated 02/16/2007 at 0615 revealed "Pt refused to have a dressing applied to underarm." Record review of nursing notes dated 02/16/2007 at 1600 revealed "patient expressed approx (approximately) 25 cc (cubic centimeters)." Record review of nursing notes dated 02/17/2007 at 0600 revealed "Pt picking at wound..he has no dressing on wound and area red, inflamed ...refuses dressing at this time x 2." Record review of nursing notes dated 02/17/2007 at 1500 revealed "pt report received from lab-culture done on 02/15/2007 on L axillae is (+) (positive) for MRSA ...physician assistant notified. Pt continues to have no dressing in place d/t (due

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to) refusal to allow nurse to place it. Pt seen messing with wound site with hands. Redirected." Record review of the laboratory culture report dated 02/17/2007 revealed "MRSA..resistant to oxacillin and penicillin ...physician assistant notified at 1225." Record review of the physician assistant order dated 02/19/2007 at 1612 revealed "Discontinue Keflex (two days and 3 hours after the physician assistant had been notified MRSA was resistant to keflex)..Bactrim DS (antibiotic that MRSA is sensitive to) po (per mouth) daily x 7 (ordered 2 days and 3 hours after lab results notification to treat the MRSA in the left axilla wound). Apply dry sterile dressings, ABD (abdominal) pad and Telfa pad to L axillary region every shift." Record review revealed patient #18 continued to go to the treatment mall. Record review failed to reveal patient #18 was placed in contact isolation when the MRSA infection in his left axilla was identified. Record review of the medication administration record sheet (MAR) dated for the month of February, 2007 revealed patient #18 had not taken every dose of the prescribed Keflex and had refused 5 of the 7 daily doses of Bactrim DS. Record review of the MAR revealed patient #18 had refused to allow the dressing changes be performed 20 out of the 24 times the dressing was required to be applied or changed.

Interview on 08/25/2007 at 1400 with the ICN revealed patient #18 had MRSA in the axilla wound, had drainage from the wound, refused to allow a dressing to be applied to contain the MRSA infection, kept touching the wound with his hands and refused the antibiotic that treated the MRSA infection. Interview confirmed patient #18 had multiple opportunities to come in contact and transmit the infection to other patients and staff

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when his wound was not covered. Further interview revealed the hospital staff failed to place patient #18 in contact isolation for a wound contaminated with MRSA as required by hospital policy.

2. Review of the policy "Resistant Organisms" revised 12/07/2005 revealed "Contact Precautions are indicated ...b. patients with wounds heavily colonized or infected with MRSA or VRE ...For patients in Contact isolation a private room or cohorting is preferable. Personal protective equipment (PPE) including gowns, masks and gloves are utilized ...Wear a gown when entering the isolation room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces or items in the patient's room, or if the patient ... has wound drainage not contained by a dressing."

Medical record review revealed patient #15 was admitted to the hospital on 07/02/2007 with the diagnosis of severe alcoholic dementia and remains hospitalized in a semi private room. Record review of a physician's order dated 08/12/2007 at 1330 revealed "Pt (patient) has methicillin-resistant staphylococcus aureus (MRSA) in abdominal wound. Placed on Contact Isolation." Record review revealed was ordered to be in contact isolation until 08/22/07, at which time the physician discontinued the order. Review of patient #15 treatment plan revealed no documentation of contact isolation. Review of the nursing notes revealed no nursing staff documentation that patient #15 was in contact isolation on 08/12-13/2007 and 08/17-22/2007.

Interview on 08/22/2007 at 1230 with the primary care nurse revealed nursing staff are to follow the

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A 749	Continued From page 97 same precautions for contact isolation as universal precautions "you wear gloves like you do with all other patients....The contact sign on the door is just to let you know they (patients) got something active." Interview revealed the nurse did not mention the use of protective gowns in caring for a patient on contact isolation. Interview on 08/24/2007 at 1346 with the Infection Control Nurse (ICN) revealed the ICN observes the units during tours but does not review patient charts. Interview revealed nursing staff should wear gloves and a gown when performing wound care and working at the patient's bedside. Interview revealed nursing staff are to document daily the patient is on contact isolation. Further interview revealed nursing staff had failed to follow contact isolation precautions by failing to wear gowns, failing to update the treatment plan and failing to document daily patient #15 remained on contact isolation for the above dates.	A 749		